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VARIOUS BILLS RELATING TO VETERANS' HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

S. 6, S. 105, S. 216, S. 631, S. 713, S. 894, S. 1195, and Related Bills

MAY 21, 1987

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CONTENTS

MAY 21, 1987

Page

Various Bills Relating to Veterans' Health Care 1

OPENING STATEMENTS

Chairman Cranston 1
  Prepared statement of Chairman Cranston 132
Senator DeConcini 150
Senator Mitchell 27
  Prepared statement of Senator Mitchell 147
Senator Murkowski 22
  Prepared statement of Senator Murkowski 142

WITNESSES

Cullinan, Dennis M., Assistant Director, National Legislative Service, Veterans of Foreign Wars of the United States 57
  Prepared statement of Mr. Cullinan 415
Dack, Jack J., Chairman, Legislative Committee, National Association of State Veterans' Homes, and Commandant, Iowa Veterans Home, accompanied by Carl Tuvin, Legislative Liaison 51
  Prepared statement of Mr. Dack 361
DeGeorge, Frank R., Associate Legislative Director, Paralyzed Veterans of America 59
  Prepared statement of Mr. DeGeorge 428
Gorman, David W., Assistant National Legislative Director for Medical Affairs, Disabled American Veterans 55
  Prepared statement of Mr. Gorman 394
Green, Dr. Howard H., Chief of Staff, White River Junction VA Medical and Regional Office Center, and member, Executive Committee, National Association of VA Chiefs of Staff 46
  Prepared statement of Dr. Green 338
Gronvall, Dr. John A., Chief Medical Director, Veterans' Administration, accompanied by Robert Lindsey, Director of Operations, Department of Medicine and Surgery; Donald Ivers, General Counsel; Yvonne K. Moody, Chief, Nursing Programs, Veterans' Administration Central Office; Dr. Howard Cohn, Deputy Assistant Chief Medical Director for Clinical Affairs; and Michael Rudd, Director, Office of Personnel and Labor Relations 4
  Prepared statement of Dr. Gronvall 152
Hawley, Dr. Peter, President, National Association of VA Physicians 50
  Prepared statement of Dr. Hawley 356
Hope, Dr. Gloria S., Director, Division of Governmental Affairs, American Nurses Association 48
  Prepared statement of Dr. Hope 343
Lloyd, E. Elaine, President, Nurses Organization of the Veterans' Administration 37
  Prepared statement of Ms. Lloyd 278
McCarthy, Dr. Sheila, Director of Nursing, George Washington University Medical Center, and President-Elect, American Organization of Nurse Executives 40
  Prepared statement of Dr. McCarthy 298
Mulholland, John, Director, Field Services, American Federation of Government Employees 43

Page
Mulholland, John, Director, Field Services, American Federation of Government Employees—Continued
  Prepared statement of Mr. Mulholland ... 306
Naylor, Dr. Mary D., Associate Dean and Director of Undergraduate Studies, School of Nursing, University of Pennsylvania ... 38
  Prepared statement of Dr. Naylor ... 289
Riggin, E. Philip, Director, National Legislative Commission, The American Legion, accompanied by Robert E. Lyngh, Director, National Veterans' Affairs and Rehabilitation Commission ... 54
  Prepared statement of Mr. Riggin and Mr. Lyngh ... 378
Thomas, Tricia, Legislative Director, National Federation of Federal Employees, accompanied by Elayne Tempel, Labor Relations Specialist ... 44
  Prepared statement of Ms. Thomas ... 326

APPENDIX

Bills:

S. 6—A bill to amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide certain new categories of persons with eligibility for readjustment counseling from the Veterans' Administration and to postpone the transition period for the Vet Center program, to authorize the establishment of a pilot program for the furnishing of noninstitutional care to certain veterans, and to increase the per diem rates paid to States for providing care to veterans in State homes; and to prohibit the excessing of certain Veterans' Administration properties; and to promote greater emphasis by affiliated health-professional training institutions on geriatric training and research; and for other purposes ... 61
S. 105—A bill to amend title 38, United States Code, to provide for the payment of incentive special pay to Veterans' Administration psychologists who obtain certain board certification in a professional specialty ... 81
S. 216—A bill to amend title 38, United States Code, to increase the per diem rates paid to States for providing care to veterans in State homes . 87
S. 631—A bill to improve the procedures for the procurement of medical and pharmaceutical supplies by the Veterans' Administration ... 88
S. 713—A bill to amend title 38, United States Code, to facilitate the recruitment of registered nurses by the Veterans' Administration ... 92
S. 894—A bill to amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to furnish certain hospital care and medical services for service-connected disabilities of certain veterans ... 97
S. 1195—A bill to amend title 38, United States Code, to provide authorities to help the Veterans' Administration overcome difficulties in the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other health-care personnel in its Department of Medicine and Surgery; and for other purposes ... 98

Letters on beneficiary travel reimbursement and quality assurance to Chairman Cranston from:

American Veterans of World War II, Korea and Vietnam ... 443
Blinded Veterans Association ... 446
Non Commissioned Officers Association ... 449
Paralyzed Veterans of America ... 451
The American Legion ... 454
Veterans of Foreign Wars of the United States ... 457

Statements:

American Occupational Therapy Association ... 459
American Optometric Association ... 467
American Physical Therapy Association ... 498
Butler, Dr. Robert N., Brookdale Professor of Geriatrics and Adult Development, and Chairman, Gerald and May Ellen Ritter Department of Geriatrics and Adult Development, The Mount Sinai Medical Center, New York, NY ... 506
Carson, John R., American Podiatric Medical Association ... 511
Clark, James W., Jr., Washington Office Director, American Optometric Association ... 512
DeGeorge, Frank R., Associate Legislative Director, Paralyzed Veterans of America ... 524
Dunbar, Sandi, President, American Association of Critical-Care Nurses ... 528

Statements—Continued

Page
Goodstein, Dr. Leonard D., Executive Officer, American Psychological Association 535
Hawley, Dr. Peter, President, National Association of VA Physicians 538
Inouye, Hon. Daniel K., a U.S. Senator from the State of Hawaii 540
Jones, Earl E., Commissioner, Federal Property Resources Service, General Services Administration 542
Magill, James N., Director, National Legislative Service, Veterans of Foreign Wars of the United States 549
Passamaneck, David J., National Legislative Director, AMVETS 551
Svenson, Elwin V., Vice Chancellor-Institutional Relations, University of California, Los Angeles 556

Written committee questions and the responses:

Chairman Cranston to:

Green, Dr. Howard H., Chief of Staff, White River Junction VA Medical and Regional Office Center 559
Hope, Dr. Gloria S., Director, Division of Governmental Affairs, American Nurses' Association, Inc 561
Lloyd, E. Elaine, President, Nurses Organization of the Veterans' Administration 563
Naylor, Dr. Mary D., Associate Dean and Director of Undergraduate Studies, School of Nursing, University of Pennsylvania 566
Thomas, Patricia, Legislative Director, National Federation of Federal Employees 569
Veterans' Administration 571
Senator Murkowski to the Veterans' Administration 573

VARIOUS BILLS RELATING TO VETERANS' HEALTH CARE

THURSDAY, MAY 21, 1987

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 8:50 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (chairman of the commitee) presiding.

Present: Senators Cranston, DeConcini, Mitchell, Graham, Murkowski, and Thurmond.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. The committee will come to order. I am glad to welcome all of you to this hearing to consider various bills focusing on Veterans' Administration health-care issues.

We are very grateful to those of you who are testifying today. I also express my appreciation to my committee colleague and very good friend, Senator Dennis DeConcini, for agreeing to take over the Chair later this morning. Due to other commitments, I deeply regret I will be unable to remain for the entire morning, but I am confident that the important work of our committee will be in very competent hands. The committee will hear testimony covering a wide variety of subjects, ranging from proposals related to ways in which the VA might respond to the health-care needs of the veteran population to proposals related to VA Central Office reorganization. Included are a large number of Administration-requested bills.

I pledged last fall that, when I resumed the chairmanship of the committee, I would generally introduce Administration bills and list them for committee hearings as appropriate, and I have done that. As the author of S. 6 introduced on January 6 and S. 1195 introduced on May 12, I will of course be very interested in the witnesses' views on those measures, as well as on Senator Murkowski's bills and Senator Mitchell's measure, and on the many other bills scheduled for today's hearing. I have a very detailed prepared statement that is available at the press table, and that will appear in full in the record.

There are several additional legislative initiatives that I want to announce this morning that will be forthcoming over the next few weeks and will be considered at a markup on July 16.

First, regarding beneficiary travel, over the past several years, there has been much discussion about the VA's revised regulations which became effective on April 13. I share the concern of those who believe that some veterans may effectively be denied access to medical care as a result of their being unable to afford transportation to a VA facility.

I know that this was a major focus of our extensive oversight hearing in Hawaii on April 14, and Senator Matsunaga has expressed great interest in rectifying the inequitable effect of the new regulations in his State. Other committee members share similar concerns.

Thus, ranking minority member Frank Murkowski and I have directed our staffs to work together to explore alternatives to the Administration's cutback and to present the committee with a bipartisan proposal for consideration on the markup of health legislation in July.

Second, regarding the Veteran Centers and their transition now mandated by law, the Senate has passed S. 477 to postpone the beginning of that transition for a year. I hope the legislation will move through the House in the next month or so; but that legislation will not be sufficient in my view, given the clear hostility to the program which this administration has continually manifested. The extraordinarily hasty and haphazard decisions made in late January to relocate nine Veterans Centers beginning on July 1—one in Wilmington has already been moved—is the latest manifestation of this animus.

My view is that careful, case-by-case periodic decisions should be made as to whether the purposes of the readjustment counseling program and the mission of the VA can best be served by maintaining a Veterans Center's community-based location or by moving it to a medical facility. There should be no fixed formula requiring such relocations on a wholesale basis as under present law. I am convinced that the current law transition requirements will lead to arbitrary decisions and to poor public policy results.

Despite our success last year in making the transition period a gradual, 2-year process, the end result under current law is still that more than half of the Veterans Centers must be closed or moved. Based on the information presently available, including a 5.4 percent increase in new clients and an 8.8 percent increase in visits at Veterans Centers, for the first 6 months of 1987 as compared to a year ago, I have concluded that the policy reflected in current law is seriously flawed. Hence, I will shortly be introducing legislation to try to ensure that decisions regarding the readjustment counseling program and the Veterans Centers are made carefully on a case-by-case basis, not with a meat ax.

This legislation would accomplish a number of objectives including, one, eliminating the statutory requirement for a fixed transition of Veterans Centers; two, replacing that transition provision with one permitting such relocation only upon determination by the Chief Medical Director that certain criteria relating to ensuring the continued availability and effective provision of readjustment counseling services have been met; three, requiring that 60 days' advance notification and detailed information be submitted to the Veterans' Affairs Committees before any such relocations are made; four, prohibiting in any fiscal year the relocation of Veterans Centers or the reorganization of any other readjustment counseling service function involving 25 or more RCS personnel, thereby allowing large readjustment counseling service reorganizations to proceed only if proposed at the time of the President's budget submission—8 months earlier—for the year in which they would occur; five, protecting the budget and FTEE ceiling for any Veterans Center relocated to a VA medical facility; six, making all war veterans eligible for, although not entitled to, readjustment counseling services; seven, explicitly authorizing the relocation at Veterans Centers of appropriate DVB and DM&S services; and eight, requiring that all Veterans Center personnel who have served effectively for a substantial period of time be converted to career positions.

I look forward to working with Senator Murkowski and all of our committee members to develop bipartisan legislation on the beneficiary travel and Veterans Center issues.

Another issue we are focusing on in this hearing is AIDS, the most serious public health issue that our nation, and indeed the world, is confronting. About 6 percent of all AIDS patients in the United States are being cared for by the VA. It has treated more than 2,000 veterans with AIDS since 1981 and will see about 1,300 this year alone. Because AIDS is a very expensive disease to treat, we must ensure that the VA has sufficient resources to care for the growing number of veteran patients with the disease.

We will be pursuing questions regarding the VA's new resource allocation methodology and how it can be modified to recognize the enormous expenses associated with AIDS treatment.

We will also be looking at the VA's policies for preventing AIDS through education and counseling for both health-care workers and veteran patients.

Finally, I want to note that yesterday I joined Senator Murkowski in releasing the GAO report on one key element to the VA's quality assurance effort—the Patient Injury Reporting Program. Senator Murkowski and I pledge to take whatever action is necessary, including developing legislation, or proceeding with oversight hearings if needed, in order to correct the serious problems identified by GAO.

I look forward to working with him and the other members of the committee on this issue, which requires immediate remedial action by the VA. We have asked the VA's Chief Medical Director to provide a full response to the report in writing and to make a full accounting of the 613 unreported incidents, as well as all the uninvestigated incidents at the nine medical centers that were surveyed.

There are obviously a great number of issues to be discussed today, all of which have great significance for the care of our Nation's veterans. I again want to thank all the witnesses for your participation and help on these important matters. We will be reviewing your testimony very, very carefully.

[The prepared statement of Chairman Cranston appears on p. 132.]

Chairman CRANSTON. Now, we will go to our first panel of witnesses, Dr. John A. Gronvall, Chief Medical Director, Veterans' Administration, accompanied by Ms. Susan Livingstone, Associate Deputy Administrator for Logistics; Mr. Donald Ivers, General Counsel; Mr. Robert Lindsey, Director of Operations, Department of Medicine and Surgery; Mr. Michael Rudd, Director, Office of Personnel and Labor Relations; and Dr. Howard Cohn, Deputy Assistant Chief Medical Director for Clinical Affairs. Thank you very much for being with us.

STATEMENT OF DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY ROBERT LINDSEY, DIRECTOR OF OPERATIONS, DEPARTMENT OF MEDICINE AND SURGERY; DONALD IVERS, GENERAL COUNSEL; YVONNE K. MOODY, CHIEF, NURSING PROGRAMS, VETERANS' ADMINISTRATION CENTRAL OFFICE; DR. HOWARD COHN, DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR CLINICAL AFFAIRS; AND MICHAEL RUDD, DIRECTOR, OFFICE OF PERSONNEL AND LABOR RELATIONS

Dr. GRONVALL. Mr. Chairman, thank you very much for the opportunity to appear and testify today. We have submitted a detailed statement dealing with each of the issues before the committee. In the interest of time, I will make very short comments now. I am assuming that our detailed statement will be entered into the record.

Chairman CRANSTON. Yes, it will.

Dr. GRONVALL. We very much appreciate the central intent of this legislative hearing to enact legislation that will help the VA with its management of a very large health-care system, and we particularly appreciate your willingness, as you noted in your opening comments, to introduce legislative proposals that have come from the VA.

Let me comment briefly on recruitment and retention of staff in our medical centers. There are numerous proposals under deliberation today that indicate the committee's interest in assuring that we have a high quality work force.

We are in fact having difficulty in many of our medical centers in maintaining an adequate work force in some particular occupations. In December 1986, we undertook a detailed survey of every one of our medical centers to document the status of recruitment and retention, and we found particularly, problems in regard to recruitment and retention of registered nurses, pharmacists, physical and occupational therapists. We face these problems because of a wide range of competitive issues with private sector hospitals, salaries, fringe benefits, working condition issues.

And in today's competitive hospital world, in order to remain in a position to recruit and retain quality staff, we are faced with the need to offer a number of additional benefits to our staff; and unfortunately, at the present time in some areas, the VA is not faring as well as we should be in this competition.

We have intensified and accelerated our use of special salary rates. As of May 10, 1987, we had 368 special salary rate authorizations in place covering approximately 10,500 employees. We have made a decision to allocate $2.5 million this year for a tuition assistance program, and this would be in addition to the scholarship program, which will be reestablished in our fiscal year 1988 operation; and we appreciate the committee's endorsement of that request to reestablish the scholarship program.

Although these initiatives have been helpful, it is apparent that much more needs to be done. We have a task force working intensively on these matters, reviewing every possible approach which might assist in recruitment and retention; and we look forward to working further with the committee as recommendations are made from the task force.

In regard specifically to the bill S. 1195, we are not able to support all of the initiatives on the agenda in that bill for reasons that are given in our detailed statement. We do support the provision that would establish a health professional education assistance program. This proposal would make a number of improvements in our health profession scholarship program and establish a tuition reimbursement program.

In regard to the many other items on the agenda, our full statement is self-explanatory; and I would mention only two other items. We have in our statement submitted the details of our major construction needs for fiscal year 1988, and we request that the committee adopt a resolution as required by section 5004 of title 38 to approve our fiscal year 1988 major medical construction project request.

Then finally, in regard to AIDS, our statement includes a short, but in some ways detailed, statement on the current status of AIDS in the VA, describing both our clinical care challenge and the research initiatives we are undertaking.

We certainly agree with your characterization of that as a major issue facing the Nation and the world, and the VA is very intent on doing its part both to treat veterans with AIDS and to assist in a major research effort so that a cure for this dread disease can be found.

Mr. Chairman, with that brief comment, I will conclude. My colleagues and I will be pleased to answer any questions that you or the committee members have. Thank you.

Chairman CRANSTON. Thank you very much for your brevity. We appreciate that, given the heavy agenda we have today.

[The prepared statement of Dr. Gronvall appears on p. 152.]

Chairman CRANSTON. Regarding staffing ratios, NOVA in its testimony prepared for this hearing states that, according to the VA's own staffing methodology, the VA needs 8,200 more nurses. Is that the correct result of the application of the VA's staffing methodology?

Dr. GRONVALL. Let me ask Mr. Lindsey, our Director of Operations, to comment on that; and Mr. Rudd may also have comments.

Mr. LINDSEY. As we look at staffing needs particularly in nursing, while there has been a decline in RNs and LPNs, I think it is our best sense that the acuity of the patient workload today requires more nursing hours to support those patients. What the total requirement would be is a bit uncertain at this time because of the changing nature of our patient workload.

Chairman CRANSTON. Do you know where NOVA and the nurses' association get their over 8,000 number?

Mr. LINDSEY. I do not know that.

Chairman CRANSTON. Would you provide a copy of your staffing ratio methodology for the committee?

Mr. LINDSEY. I certainly will.

[Subsequently, the Veterans' Administration furnished the following information:]

The attached DM&S Policy Directives provide guidelines for determining staffing for various nurse requirements. Further guidelines are under development.

[The DM&S Policy Directives appears on p. 197.]

Chairman Cranston. How do staffing ratios at the VA compare to medical school hospitals or other community hospitals accredited by the JCAH?

Mr. Lindsey. I believe historically the staffing ratios in VA medical centers are less than those in the medical centers that you have alluded to.

Chairman Cranston. By how much?

Mr. Lindsey. I don't have the exact figures. We can provide that for the record, because those staffing ratios are changing also.

Chairman Cranston. If you would, please, give us the historical record.

[Subsequently, the Veterans' Administration furnished the following information:]

No national data exist regarding ratios of nurses to patients cared for, patient mix, number of beds occupied and/or the intensity of nursing care provided. Neither the American Hospital Association nor the American Nurses' Association collect such statistics and the private sector is very guarded when releasing such information. It is unlikely that such data will be collected in the foreseeable future based on the wide variation in types of hospitals, i.e., profit, not for profit, teaching, community, research based, general, specialty oriented, acute or long-term care as principal examples. This is further compounded by significant variations in the nature and mix of the patient population, number of critical care beds, and type of care provided. In addition, tremendous variations in the basic educational preparation of professional nurses, their work experience and availability to work in a labor shortage market preclude a common base that is reliable and valid in developing a ratio of nurses to patients. It is also to be noted that the private sector has or is rapidly moving toward total registered nurse staffing. In the VA system, there is only one totally registered nurse staffed Nursing Service; it is VAMC San Antonio.

Based on 1987 estimates from *Medical Programs, Fiscal Year 1987*, Volume II, February 1986, the ratio of registered nurses to average operating beds (total VA) is 1:2.90.

A telephone survey during the week of January 4, 1987 to VA Chief Nurses and Directors of Nursing Service in the private sector revealed the following:

Facility	Nurse: Operating bed ratio
San Antonio VAMC	1:1.42
University of Texas Health Science Center	1:1.18
Cincinnati VAMC	1:2.04
University Hospital	1:0.94
Kansas City VAMC	1:2.37
University of Kansas College of Health Sciences and Bell Memorial Hospital	1:1.67
Minneapolis VAMC	1:1.58
University of Minnesota Hospital and Clinic	1:0.49
Washington, D.C., VAMC	1:2.23
Washington Hospital Center	1:0.86 (1:0.73)*
Palo Alto VAMC	1:3.01
Stanford University Hospital/Medical Center	1:0.97
Denver VAMC	1:1.54
University Hospital	1:0.70
Gainesville VAMC	1:2.11
Shands Hospital	1:0.60
Pittsburgh (UD) VAMC	1:2.61
Presbyterian University Hospital	1:1.16
West Haven VAMC	1:2.69

Facility	Nurse: Operating bed ratio
Yale-New Haven Hospital	1:0.70
Seattle VAMC	1:1.60
University Hospital	1:0.62
Bronx VAMC	1:2.32
Mt. Sinai Medical Center	1:0.75

* Ratio increases with utilization of contract nursing personnel. Authorized registered nurse ceiling is 953; staff expanded to 1,111 with contract personnel on the day of contact.

In all examples (N=12) the ratio of registered nurses to operating beds was lower in the VA than at university affiliated hospitals.

Although there is no national data regarding ratio of nurses to patients, the VA is developing patient care measurement tools. The first VA nursing staffing guidelines were implemented in 1982. The guidelines provide a more objective basis for determining core nursing staffing (nursing personnel at the "care-giving" level) requirements. They are a method of classifying patients according to their nursing care requirements related to dependency and amount of direct nursing care provided. The guidelines indicate the hours of nursing care required per patient per day by category of patient. According to VACO Manpower Planning Division, 70 percent of nursing personnel are currently covered by staffing guidelines; others are in development phase. Staffing allocations and guidelines generally reflect the nursing needs of the inpatient population. Nursing has responded to the overwhelming and continuing growth in ambulatory care activity by dedicating resources although there is no current provision for them in resource allocation or staffing guidelines.

Variations in patient condition, as well as wide differences in knowledge and skill level of nursing personnel performing prescribed activities necessitate the utilization of the guidelines in concert with professional judgment. The dynamics of patient care such as new technologies/procedures, multiple needs of the elderly veteran, and increased intensity of illness impact on the guidelines necessitating their periodic evaluation and update. Therefore, one should consider them broad indicators of patient care requirements.

In summary, the quantification of patient care measurements is a beginning science. There is currently no precise measure to adequately compare the VA with other private or public sector hospitals. The staffing guidelines are a significant but first generation step towards answering questions of comparability and staff.

Chairman Cranston. Do you believe that the VA has sufficient nursing staff now?

Mr. Lindsey. Our feeling on that is that, because of the pay rates that the VA is paying currently, we find ourselves in many instances not comparable in pay rates with the other sector, and we need to improve that. And that will allow us to attract and retain additional nursing personnel.

Chairman Cranston. Whatever the pay situation, do you believe that you now have in the VA sufficient nurses?

Mr. Lindsey. Currently, the answer to that is we need more nurses, more nursing staffing in our medical centers.

Chairman Cranston. Do you need higher ceilings, or are you just not fully staffed at the present?

Mr. Lindsey. We are not fully staffed at the present time.

Chairman Cranston. Do you need higher ceilings also?

Mr. Lindsey. Our feeling is that if the medical centers could hire up to the ceilings that they have authorized, then that is sufficient to get our job accomplished.

Dr. Gronvall. Mr. Chairman, I might add just a short comment on that. As we have followed carefully our status on nursing staff over the past several years, we were making slow but important progress in expanding our nursing staff, both RN and LPN. Beginning about 6 to 8 months ago, as a result of the competitive pressure in the nursing market, our total RN staffing began to decline.

I would have to supply the exact figure, but I believe in the past 6 months we have declined about 600 total nurses staffing our hospitals. We are clearly short by that amount. I agree with Mr. Lindsey that, in comparison to some other hospitals, we have always been on the lean or short side in terms of our staffing ratios.

Chairman CRANSTON. If 8,200 slots for additional nurses were authorized and filled, would staffing ratios be comparable to medical school hospitals and other community hospitals that are accredited by JCAH?

Dr. GRONVALL. That number would surely significantly improve the quality of our staffing ratios. Again, whether it would make it fully comparable with some particular groups of hospitals would have to be based on reviewing the data.

Chairman CRANSTON. Would you take a look at that and answer that for the record?

Dr. GRONVALL. We would be pleased to.

Chairman CRANSTON. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

As previously discussed, no national data exist regarding ratios of nurses to patients cared for, patient mix, number of beds occupied and or the intensity of nursing care provided. When the nursing staffing guidelines are completed for nursing personnel, we will be in a better position to assess VA nursing staff needs. The addition of 8,200 nurse slots would significantly improve the quality of our nursing progams.

Chairman CRANSTON. The American Federation of Government Employees' testimony in discussing issues pertinent to employee moral and productivity states that "in an atmosphere purportedly designed for health care, there are no wellness programs for staff." What is your reaction to that statement?

Dr. GRONVALL. Of course, I have not seen the statement before you just asked the question. Mr. Lindsey may be able to comment on activities within our medical centers that would fall under the heading of wellness. Part of our statement makes the comment that we are developing a nationwide program to increase the overall attractiveness of the VA as an employer. That is one of the issues along with many others that we are looking at to make a change in the degree to which we are attractive as an overall employer. Mr. Lindsey, could you comment?

Mr. LINDSEY. I could not add anything else.

Chairman CRANSTON. Do you think there is any need for such programs?

Dr. GRONVALL. I think it has certainly been demonstrated in this country that wellness/fitness programs and a number of other similar kinds of benefits and programs for employees do make a difference, both in recruitment and retention, and in morale and, therefore, the effectiveness of the staff employed. That is not a hospital issue; that is an employment and organizational issue.

Chairman CRANSTON. I would like to ask you one question, Mr. Ivers. Do you believe they need statutory authority to provide such programs?

Mr. IVERS. Specifically as a wellness program for employees only, I believe we would need statutory authority. Yes, sir.

Chairman Cranston. For the record could you give us a technical draft of what you think would be needed?

Mr. Ivers. Yes, sir. We would be glad to.

[Subsequently, the Veterans' Administration furnished the following information:]

The current authority for establishing employee Health Service programs is found in 5 U.S.C. § 7901. We reviewed the press release of the AFGE on "Wellness Programs" distributed at the hearing and found no decription of the programs. We called Mr. Mulholland, AFGE Director of Field Services, who advised us that specific proposals were being prepared which would be presented to the VA. We will consider these proposals when they are received. Whether or not new statutory authority is needed for these programs will depend on their nature. We will gladly provide a technical draft of statutory language if it is needed.

Chairman Cranston. John, AFGE's testimony also states that "if Congress allowed these title 5 employees on-call pay, the existing voluntary system would become viable and yet would not penalize particular individuals." As an alternative to your proposal in S. 1065, if you provided title 5 employees with the option of remaining at their duty stations and earning standby pay as at present or being available by telephone and paying them at the on-call rate, would this not provide the required number of employees to adequately meet the hospital's needs while, at the same time, still reducing operating costs since employees might choose to take the at-home option, even though they might lose a little compensation?

Dr. Gronvall. I don't think that is a question I can answer just sitting here. To make an informed response would require, I think, some thought and analysis since that is a very detailed proposal. We would be glad to submit a comment on that.

Chairman Cranston. Fine. Would you do that, please?

Dr. Gronvall. We would be pleased to.

[Subsequently, the Veterans' Administration furnished the following information:]

In reviewing the proposal to provide title 5 health care employee with the option of choosing between standy pay or title 38 on-call pay, the following considerations apply:

—Presently, employees currently receiving standby pay generally have their home designated as the duty station while in standy status.

—An employee who is regularly called back to work will generally receive about the same or more compensation under the on-call system as under the standby.

—Employees are paid for actual hours of on-call and call-back under the title 38 system rather than the projected average hours under title 5 standby.

—The on-call system affords employees more flexibility in that beepers can be issued and the employee need not remain "at home" if reachable by phone or beeper. Under the standy system an employee must be at his/her designated duty station while in a standby status.

—On-call systems are commonplace among health care workers in the competitive marketplace; lack of familiarity with an unknown standby system may be a recruitment deterrent. In this respect an on-call system could improve the competitive position of a VAMC.

—Scheduling in a hospital setting is already time-consuming and logistically difficult. The additional complexities of potentially providing coverage within the same work unit, according to employee interest, under both a standby and an on-call system could create an administrative nightmare.

In view of these considerations and other possible difficulties, the VA feels that it is most reasonable for management to retain the right to determine how the hospital's coverage needs will be met, i.e. which scheduling practices will be followed. Therefore, it is our belief that it would be best to permit individual facility directors to determine which system will best suit the needs of the particular medical center and its patient population.

Chairman **Cranston**. Section 5545 of title 5 requires employees on standby to be paid at least 5 percent or as much as 25 percent of their basic rate of pay for each hour spent on standby. Could you provide for us in writing the criteria used to determine the rate between 5 and 25 percent which the employee will be paid?

Dr. **Gronvall**. We would certainly be pleased to do so.

[Subsequently, the Veterans' Administration furnished the following information:]

The criteria for determining the correct rate of standby pay is contained in 5 C.F.R. 550.144(a) (3) and (4). It is summarized as follows:

- —For an employee with a basic workweek requiring full-time performance of actual work who is required to provide additional standby coverage as follows:
  - —14 to 18 hours per week on regular workdays or extending into non-workdays, standby rate = 15 percent.
  - —19 to 27 hours per week on regular workdays or extending into non-workdays, standby rate = 20 percent.
  - —28 or more hours/week on regular workdays or extending into non-workdays, standby rate = 25 percent.
- —For an employee with a basic workweek requiring full-time performance of actual work who is required to provide standby duty as follows:
  - —7 to 9 hours on one or more regular weekly non-workdays, standby rate = 15 percent.
  - —10 to 13 hours on one or more regular weekly non-workdays, standby rate = 20 percent.
  - —14 or more hours on one or more regular weekly non-workdays, standby rate = 25 percent.
- —If an employee is expected to provide Sunday coverage, an agency may increase above calculated rates for Sunday work as follows:
  - —For 20 to 40 Sundays per year, increase standby rate by 2.5 percent.
  - —For 41 or more Sundays per year, increase standby rate by 5.0 percent.
- —In no case may the total standby rate exceed 25 percent.

Chairman **Cranston**. I would also appreciate it if you would provide as soon as possible a full written description of your $2.5 million experimental tuition reimbursement program being implemented this fiscal year.

Dr. **Gronvall**. Yes, we would surely be happy to do so. It is just getting under way, and we would be pleased to describe that.

Chairman **Cranston**. Fine.

[Subsequently, the Veterans' Administration furnished the following information:]

A recent Veterans' Administration Office of Personnel and Labor Relations survey revealed that some VA medical centers are experiencing difficulties recruiting and retaining an adequate supply of personnel in the following occupational categories:

Nursing Assistants
Licensed Practical Nurses
Registered Nurses
Occupational Therapists
Physical Therapists
Pharmacists
Respiratory Therapists
Dental Assistants
Dental Hygienists
Diagnostic Radiologic Technician/Technologists
Therapeutic Radiologic Technician/Technologists
Echocardiograph Technicians
Nuclear Medicine Technician/Technologists
Opthalmologist Technicians
Pulmonary Function Technicians

Since lack of funding for tuition/educational assistance was reported to have a negative impact on VA facilities' recruitment and retention ability, the Department of Medicine and Surgery targeted $2.5 million in fiscal year 1987 to enable VA medical centers to provide tuition support/reimbursement for personnel who are currently employed in, or wish to move into, one of the above cited occupational categories. Funds may be used for continuing education programs or academic courses that are: (a) Related to the duties of one of the identified categories, and (b) Conducted by an approved CE provider or an accredited academic institution.

VA medical centers interested in obtaining fiscal year 1987 tuition support funds have been asked to submit applications to the Department of Medicine and Surgery's Office of Academic Affairs. Funds will be awarded to those VAMCs and occupations where recruitment and retention problems are most critical.

Chairman CRANSTON. I appreciate your support of the provisions for the tuition reimbursement under S. 1195.

Dr. GRONVALL. Yes. I am quite optimistic that that will make an impact, both a direct impact with the individuals also but importantly also the symbolism that we care about these problems and are doing something about it on our own initiative.

Chairman CRANSTON. Fine. John, Dr. Green, in his written statement, describes an educational program taking place at the White River Junction VAMC, that he is in the process of establishing with the Vermont College School of Nursing. As he describes it, qualified VA staff members would be given a joint appointment with the school and teach clinical courses to students on site at the VAMC. Nonnursing courses would be taught by college faculty, again in classrooms at the VAMC. These classes, which would be available to all VA employees, would be offered at times convenient to students and at no tuition cost.

Would you agree that this seems like a very useful, cost-effective program?

Dr. GRONVALL. I have not been aware of the details of that program and have not had a chance to read his testimony. As you describe that, it certainly sounds like an admirable effort. We have, I think, in many of our medical centers a very creative partnership and affiliation relations between the VA, nursing schools, medical schools. Those do make a difference and are very desirable. I would be pleased to look at the details of that one in particular and provide a comment on it for you.

Chairman CRANSTON. Fine.

[Subsequently, the Veterans' Administration furnished the following information:]

The White River Junction VA Medical and Regional Office Center (VAM&ROC) in conjunction with the Vermont College School of Nursing, has developed a plan to help attract and retain nurses at the VA center. The plan is scheduled for implementation in September 1987. Qualified nurses from the White River Junction VAM&ROC will be appointed as adjunct professors at Vermont College, School of Nursing. Employees of the VA center will then be eligible to take courses leading toward a nursing degree with no tuition charge. The classes, both clinical and nonclinical, will be held at the VA center to accommodate the employees' schedules. The non-nursing courses such as basic science and humanities will be opened to employees interested in non-nursing degrees if space is available. The program is designed to help licensed practical nurses, nursing assistants and registered nurses without degrees accomplish a degree in nursing.

The Department of Medicine and Surgery knows that other medical centers have implemented similar programs in nursing and other associated health areas. These programs help develop skills, abilities and knowledge required for a well qualified work force plus serve as inducements for recruiting health care professionals into the VA. We will continue to encourage such programs.

Chairman CRANSTON. Presuming that it is both useful and cost-effective, what could be done to promote the replication of that program at other VAMCs?

Dr. GRONVALL. As a generalization, when one of our medical centers initiates a program of that sort that works, we publicize it, make our other medical centers aware of it, make the information known through our Regional Medical Education Center Program and our Academic Affairs Programs, and that provides helpful guidance to other medical centers to capitalize on good ideas that have been developed.

Chairman CRANSTON. If you would get back to us when you can on your analysis of its beneficial nature; and if that is your conclusion, what you could do to spread the ideas?

Dr. GRONVALL. Good. I would be pleased to. And as a matter of fact, I have an appointment to meet with Dr. Green tomorrow. So, I look forward to discussing it in more detail personally with him.

[Subsequently, the Veterans' Administration furnished the following information:]

The White River Junction VA Medical and Regional Office Center/Vermont College School of Nursing cooperative educational effort which is scheduled to begin in September 1987 appears to be a useful, beneficial initiative. The Department of Medicine and Surgery's Office of Academic Affairs is containing an article on the program in its July 1987 newsletter which is distributed to all VA medical centers. In addition we are requesting VA medical centers to submit articles describing innovative, cooperative educational arrangements they may have with schools and universities to this newsletter so they may be shared with others.

Chairman CRANSTON. Thank you. I have a few questions for the nursing service with regard to the Tuition Reimbursement Program. Would you identify yourself for the record, please?

Dr. GRONVALL. Let me introduce Yvonne Moody from our nursing service who can respond directly to your questions, Mr. Chairman.

Chairman CRANSTON. Thank you. We are glad to have you with us.

Ms. MOODY. Thank you, Senator Cranston.

Chairman CRANSTON. If the program did not require that a nurse work for 2 years in the VA and demonstrate superior performance, how many individuals do you think would apply for the program?

Ms. MOODY. We believe that roughly 10 percent of our hospital personnel would apply for the Tuition Reimbursement Program.

Chairman CRANSTON. About 3,200?

Ms. MOODY. About that. Yes, sir.

Chairman CRANSTON. In your testimony, you estimate that the first year program costs for the Tuition Reimbursement Program would be $5 million. Would that cover the cost of all nurses who would apply, given the circumstances described in the previous question?

Ms. MOODY. Based on our estimates, yes.

Chairman CRANSTON. Don't you think a morale problem would be created if newly employed nurses could compete for tuition reimbursement on an equal footing with senior VA nurses?

Ms. MOODY. We believe that the availability of the Tuition Reimbursement Program would serve to attract new employees to our facility as well as retain those who are already on, and the effects would be balanced off.

Chairman CRANSTON. You don't think that there would be an inequity or a morale problem stemming from this new equality for the new ones?

Ms. MOODY. No, we do not.

Dr. GRONVALL. Mr. Chairman, if I might make just a general comment to your question? That factor, of course, is one we always take into account. In our testimony, for example, in regard to the bonus bill that has been proposed, we make some comments about wanting to work further on that and other similar measures to ensure that we don't create an inequity between newly hired and our long-term, dedicated staff that we depend so much on to carry the workload. So that factor is surely important to us.

Chairman CRANSTON. If the bill were changed so that priority was given first to nurses with 2 years work experience and superior performance and, second, to all other nurses with 2 years experience, would that help overcome any potential morale problems and still allow desirable flexibility in the program?

Ms. MOODY. We believe that the Tuition Reimbursement Program should be as flexible as possible to permit both retention and recruitment of nursing personnel and that the actual implementation of how it is to be developed would be determined by perhaps the field facilities.

Chairman CRANSTON. Dr. Gronvall, I would appreciate it if you would give a response in writing to that last question.

Dr. GRONVALL. I would be pleased to.

[Subsequently, the Veterans' Administration furnished the following information:]

The Department of Medicine and Surgery (DM&S) believes the Tuition Reimbursement Program proposed in the Veterans' Administration Health-Care Personnel Act of 1987 will help us address the recruitment and retention problems many VA medical centers are currently experiencing. We do not believe that tenure with the VA should be legislated as either a requirement for eligibility or consideration for priority in this program. Rather, DM&S should be given flexibility in its implementation of this program to determine eligibility and priority. As we currently envision the program, the eligibility requirement would be the equivalent of 1 year full-time service with the VA with no priority consideration for length of service. We believe this would make the program even more appealing, both in terms of recruitment and retention of health-care personnel.

Chairman CRANSTON. Fine. I would like to turn to the matter of AIDS. John, when you testified during our committee's budget hearing on February 18, you indicated that adjustments in patient allocations would be made within a month for AIDS treatment for fiscal year 1987 and that the adjustments for fiscal year 1988 were going to be incorporated in the basic budget allocation. Have you made the adjustments for fiscal year 1987?

Dr. GRONVALL. No, sir. That has not been completed, although I have reviewed the matter several times with the staff. And the reason we haven't completed that allocation during this year is that the issue is complex; it is changing rapidly. It has been complicated by the fact that we have had additional costs involved in an AIDS-related complex patients and the care and treatment of those, which is an additional issue. So, we have wanted to ensure that we have the best information in finally making an allocation.

I am expecting shortly a recommendation from our operations people regarding an allocation this year.

Chairman CRANSTON. When is the money going to get to these destinations? You told us on February 18 it would be 1 month.

Dr. GRONVALL. Yes.

Chairman CRANSTON. There are a number of stations that are starving for money, spending much more than is available to them, and they need to have this matter resolved.

Dr. GRONVALL. Yes. We have conferred, of course, with the staffs at the medical centers that are carrying the largest amount of the load. What I think I would prefer to do is quickly give you a written reply indicating when we will make an allocation; and it will be in the very near future.

Chairman CRANSTON. How soon can you give us that specific date?

Dr. GRONVALL. We can give you that letter within a few days, with a specific date.

[Subsequently, the Veterans' Administration furnished the following information:]

We notified the committee of the allocation of special funding for AIDS treatment in VA Medical Centers on June 12, 1987.

Chairman CRANSTON. Can you commit on being able to distribute the money by early June?

Dr. GRONVALL. Yes.

Chairman CRANSTON. What progress have you made with regard to the fiscal year 1988 adjustments?

Dr. GRONVALL. Yes. We have not adopted a final decision on any of the resource allocation model recommendations that we are considering for fiscal year 1988. We have been working with a large task force that includes a considerable number of people from our medical centers to ensure that we deal not only with that question but other questions as well. Again, within the next few weeks, we will be acting on a set of recommendations that include that item for fiscal year 1988.

Chairman CRANSTON. You indicated in your February 18 statement that the adjustments for 1988 were going to be incorporated in the basic budget allocation; and that will still be the case?

Dr. GRONVALL. Mr. Chairman, that is my intent and we intend to do that. As fiscal year 1988 rolls along during the course of the year, if it becomes apparent that the problem has changed, or worsened, the fact that we included something in the initial allocation to deal with it that may be inadequate would cause us again to consider a special allocation. I think we need to stay flexible every year on that matter.

Chairman CRANSTON. I thank you for answering the question I should have asked.

Dr. GRONVALL. Oh, thank you.

Chairman CRANSTON. And if you could let us know the moment you have done that for fiscal year 1988?

Dr. GRONVALL. I surely will.

[Subsequently, the Veterans' Administration furnished the following information:]

For fiscal year 1988, a manual adjustment will be made to the RAM initial allocation to compensate those medical centers that have had a significant number of AIDS cases and, subsequently, Diagnostic Related Groups (DRGs) will be developed within the RAM for AIDS cases. We anticipate making the initial allocation for fiscal year 1988 in late August or early September.

Chairman CRANSTON. With no vaccine against AIDS available, information about AIDS and how the virus is transmitted are the only tools available to prevent the further spread of the disease at present. In addition, educational programs for health-care workers and other hospital employees are crucial to help workers stay up-to-date on the latest treatments and to ensure that the fear and hysteria regarding this disease is minimized. What kinds of guidelines or agency-wide programs, if any, have to be initiated with regard to AIDS prevention and education?

Dr. GRONVALL. Mr. Chairman, let me ask Dr. Howard Cohn to comment on your question.

Dr. COHN. Mr. Chairman, we have several mechanisms to get at your question. One is, of course, VACO directives or circulars; and I can tell you that we have issued 17 of those to field facilities. Any number of them do refer specifically to guidance which has been published by the Centers for Disease Control, and of course, we look to the U.S. Public Health Service and their divisions as the lead agency in dealing with the entire epidemic. In more specific terms in regard to training of staff, in fiscal year 1985 129 VA medical centers conducted locally sponsored educational programs, which trained in excess of 30,000 VA staff persons.

In fiscal year 1986, 12 of our Regional Education Centers sponsored AIDS programs, and there were approximately 1,240 participants at those 12 REMC programs. In addition, there have been four continuing education activities sponsored by Cooperative Health Manpower Education Programs in fiscal year 1986, and there were 53 VA participants in those programs.

There are to be three RMEC sponsored AIDS programs in 1987, namely Birmingham, Cleveland, and Seattle. I personally participated in the Seattle meeting, which was held on May 14 and 15, and I have been invited to and will attend the programs that are scheduled in the other sites.

It is anticipated that upwards of 500 participants from the VA will be involved. So, I would say we have a multiple manner or multiple ways of getting at the very key issue that you bring up.

Chairman CRANSTON. What are you doing in regard to education and outreach to patients and prospective patients?

Dr. COHN. Frequently patients are invited to these sessions. For example, there may actually be a panel of AIDS patients—of course, a relatively small number—as in the case of the Seattle RMEC that I referred to, in which there was a panel composed of three AIDS patients.

We provide leaflets and circulars. We distributed approximately 90,000 copies the Surgeon General's report on AIDS to the system.

There are, of course, patient health education activities in all of our medical centers—coordinators if you will—that are actively involved. Now, I do not want to give the impression that this is universal across the system.

As the Chairman knows, the overall problem of course affects the VA differentially. And the major medical centers on our three coasts and San Juan are the major centers involved.

There are some alarming concerns, however, that the epidemic is spreading internally in the country; and indeed, it is my personal opinion that all medical centers must be geared for the exigency of managing and caring for AIDS patients.

Chairman CRANSTON. Thank you very much. John, I think we really need an aggressive program of education for drug users, for example, and others most susceptible to this disease. I would like you to take a look at what you can do, beyond what is now being done, to reach those who are already patients with AIDS or have lifestyles that might lead to becoming a patient with that disease.

Dr. GRONVALL. We will surely do that.

Chairman CRANSTON. And if you would report back to us on that?

Dr. GRONVALL. We would be pleased to.

[Subsequently, the Veterans' Administration furnished the following information:]

> We have reviewed your suggestion and agree. As an initial step, we will be establishing an education component specifically on AIDS as a requirement for all of our Drug Abuse Treatment Programs.

Chairman CRANSTON. Senator Thurmond, you have been very patient. Do you have questions or a statement?

Senator THURMOND. Yes, thank you, Mr. Chairman. Doctor, I don't have any prepared questions, but I am very interested in the veterans, not just because I am a veteran, but because of the great service they have rendered to our country.

If it were not for the men and women in uniform, we would not have freedom today. Now, I just want to ask a few questions here. What is the official name of the department you head?

Dr. GRONVALL. That is the Department of Medicine and Surgery.

Senator THURMOND. That is the name of it?

Dr. GRONVALL. Yes, sir.

Senator THURMOND. How many people do you have in that department?

Dr. GRONVALL. Our staff are supported by three different appropriations. The Medical Care Appropriation is estimated to support a total of 194,140 FTEE in fiscal year 1987. We have a research appropriation which is estimated to support 4,642 FTEE in fiscal year 1987. And our Central Office Administration appropriation is estimated to support some 591 FTEE in central headquarters.

Senator THURMOND. Now, of course, in the veterans, you have got a housing department and you have various other things, the pension department and so forth. The field of health is what I am talking about now.

Dr. GRONVALL. Correct. All of the figures that I gave you all relate to the health system of the VA.

Senator THURMOND. If you don't have them with you, if you could supply those figures, I would appreciate it, if you would send them to me?

Dr. GRONVALL. Yes, sir. I will be glad to.

Senator **Thurmond**. Now, I want to know the total number, so to speak, of all the health personnel.

Dr. **Gronvall**. Yes. And those figures that I gave are FTE figures, not the head count of people. A part-time person would count as half of an FTE or some fraction.

Senator **Thurmond**. I see.

Dr. **Gronvall**. So, the appropriation is put in FTE terms, and that is what we would give you for the total health system.

Senator **Thurmond**. How many doctors do you have under you?

Dr. **Gronvall**. Directly employed, full-time physicians in the hospital system is some 12,000 plus. Again, I don't have that figure at my fingertips.

Senator **Thurmond**. If you would furnish that then?

Dr. **Gronvall**. I would be pleased to furnish it.

Senator **Thurmond**. How many nurses do you have?

Dr. **Gronvall**. About 35,000.

Senator **Thurmond**. Would you supply that, too?

Dr. **Gronvall**. I will supply that, too.

Senator **Thurmond**. How many different hospitals under your direction?

Dr. **Gronvall**. 172.

Senator **Thurmond**. How many nursing homes?

Dr. **Gronvall**. 116, I believe, is the figure.

[Subsequently, the Veterans' Administration furnished the following information:]

	FTEE
Medical Care Appropriation—FY 1987 estimate	194,140
Research Appropriation—FY 1987 estimate	4,642
MAMOE Appropriation—FY 1987 estimate	591
Total	199,373

CATEGORIES OF HEALTH CARE PERSONNEL

As of Mar. 31, 1987	Full time	Part time/int	Total
Physicians	7,056	5,480	12,536
Nurses	31,363	3,900	35,263
Residents			10,546

Senator **Thurmond**. Now, do you have any plans to build any more hospitals, or is it now adequate?

Dr. **Gronvall**. We have plans to add a hospital, in other words, a 173rd hospital in Palm Beach County, Florida. The planning for that project is moving through the system now.

We had earlier made planning projections that would call for additional hospitals, particularly in Florida. None of those others are firmly committed in terms of construction funds.

Senator **Thurmond**. Land is awfully high in Florida. Do you reckon you could get it cheaper in South Carolina and do it there? [Laughter.]

Senator **Thurmond**. We have mighty good climate down there.

Dr. **Gronvall**. I am well aware of that, sir.

Senator **Thurmond**. We have a change of season, but we don't have ice and snow like they do in other parts of the country.

Dr. GRONVALL. Yes, sir.

Senator THURMOND. It is pretty hot in Florida mostly year round. You might think over that.

Dr. GRONVALL. We will certainly think of that; and of course, the thing that leads to the decision as to where a hospital will be is where the veterans are. And so——

Senator THURMOND. They would be aware of where the hospitals and nursing homes are, so they would go wherever they are, I imagine.

It is amazing what a fine job the VA has done. I just want to compliment all of you who are connected with it.

Dr. GRONVALL. I thank you, Senator.

Senator THURMOND. I have eight doctors in my family, and I am very interested from the health standpoint and in the health of people generally. I think you have done an outstanding job and deserve to be commended. Sometimes, incidents come up that may give the VA a bad reputation.

For instance, in Charleston a few years ago, I think they had an intern who operated on a veteran there; and I think he cut a nerve and paralyzed him. I believe that case was settled; I don't know whether you are familiar with it or not.

Dr. GRONVALL. I do recall.

Senator THURMOND. But at any rate, if there had been an experienced surgeon there with that young man, it might not have happened. I just wondered what is your policy now. Do you have experienced surgeons working with the inexperienced young doctors starting out?

Dr. GRONVALL. Yes, sir. Let me, if I may, make a slightly more general comment and then answer that in that context. Within the past year, in fact, at a congressional hearing, we had the opportunity to review in a very detailed way the total malpractice experience of the Veterans' Administration. On the one hand, I am sad to have to say that we have had tragic incidents in the VA of malpractice with tragic outcome. On the other hand, I am very happy to say that, based on all of the evidence that we have been able to get, our malpractice experience is at a much smaller rate than is the case in community hospitals or other hospital systems that we have been able to compare.

Senator THURMOND. A smaller ratio and fewer cases?

Dr. GRONVALL. Yes. No case is acceptable. I would not want to leave that impression; but unfortunately, in a human system, tragic errors are made. To comment more specifically to the point you made, we have in the past 2 years strengthened our requirements for supervision of physicians who are in a learning status; and we have taken steps to ensure that our practice is that, in every instance where surgery is being done, a full-licensed, competent and responsible physician is there and responsible and that, where resident surgeons who are in training are carrying out the surgery, they are operating within the supervision of a responsible physician and they are doing things only that they are judged to be competent to do.

Senator THURMOND. In other words, you have taken steps in the last few years then to provide more supervision for the younger doctors?

Dr. GRONVALL. Yes, sir.

Senator THURMOND. Especially those doing surgery?

Dr. GRONVALL. Yes, sir, very specifically.

Senator THURMOND. I am glad to hear that because there were several instances, and I just remembered the one in Charleston that I mentioned. And of course, that is unfortunate for the veteran and also, then, it is unfortunate for the taxpayers because they have to pay a large sum of money.

Dr. GRONVALL. Yes. That particular case you referred to was one that very dramatically attracted our attention. It was one of the important stimuli to us to tighten our requirements for supervision.

Senator THURMOND. I am glad to hear you have done that, and I want to commend you for it.

Dr. GRONVALL. Thank you.

Senator THURMOND. And as much work as you do, again, I think it is remarkable that you have done such a fine job because you really have the largest health responsibility of any place in the world, don't you? Don't you have more hospitals, more nursing homes, and more people to care for than any other place in the world?

Dr. GRONVALL. I believe that is correct. It is certainly correct, at least, in the free world.

Senator THURMOND. Now, there is an application pending for a nursing home at Anderson, South Carolina. I believe it has been under consideration for several years now. Do you know the status of that?

Dr. GRONVALL. I am sorry, sir, that I don't know the details. I would certainly be glad to look into it, and I could get back to you on that.

Senator THURMOND. I would like to know the status of that.

Dr. GRONVALL. I would be pleased to.

[Subsequently, the Veterans' Administration furnished the following information:]

The application for the 220 bed veterans nursing home at Anderson, South Carolina, was received in August, 1984.

All phases of the project have been completed to the point where we are awaiting final drawings and specifications from South Carolina for our review for compliance of VA mandatory requirements.

Senator THURMOND. I want to ask you a question about AIDS. We are all hearing so much about that now and how dangerous it is. I believe I read in the paper yesterday about three people who were contracting AIDS and it wasn't because of a sexual relationship but because of being around patients that had the AIDS disease; and blood spattered or something.

Have you any evidence that there is any way AIDS can be contracted except through sex?

Dr. GRONVALL. Yes, there surely are. Let me make a very general comment, and then I will ask Dr. Cohn to be more specific. The three cases that you referred to we were aware of, in fact, before they were reported because we had been supplied with detailed information from the Centers for Disease Control because of our very great interest in being sure that we are aware of all of that kind of information and take steps within the VA as appropriate.

Let me ask Dr. Cohn to make comments on your question.

Dr. COHN. Yes, sir. With respect to transmissibility, basically we are talking about three kinds of transmission: intimate sexual contact that you have alluded to, blood and blood products—principally the use of dirty needles by IV drug abusers—and so-called "vertical transmission." That would be from mother to child.

I have reviewed the CDC reports of the three cases that you allude to, and I have some comments about that if you would care to hear those. These cases certainly deserve our undivided attention. We are literally living through the history of this epidemic; so I don't think that we can be particularly surprised or shocked really at any bulletin or news item or research finding that comes along because we are literally living through it.

As such, we must be prepared for any eventuality that occurs, such as new modes of transmission, as these cases may represent—underscored—new rates of causation of the disease.

Now, in terms of splashes and mucous membrane contact, which was the nature of the exposure in these three situations, such type of accidental exposure to blood or blood products in the health-care setting must be extremely frequent and certainly much more frequent than needle stick injury, which is all too frequent as it turns out.

So, these three cases—at least in the minds of CDC that has analyzed the three—must be extremely rare events because of the frequency of the splash or the contact.

I would refer you to the fact that there are a number of surveillance studies of individuals in health-care settings, for example, exposed to needle stick. For example, the CDC has a cooperative studies trial going on in which they have looked it over—1,000 instances of needle stick. And in only one of those individuals was there evidence of sero positivity or conversion to HIV positivity from a previously negative state.

So, obviously, we are talking about an extraordinarily low incidence of transmission by even the route of needle stick. So, if we, for example, would compare this kind of transmission of an infectious agent to, say, Hepatitis B, we are talking about an extremely low rate of transmission as compared to that virus, which epidemiologically is quite similar in terms of its transmission, namely Hepatitis B.

I think it also points out that precautions must be taken obviously by all health-care workers in these settings, and I might say that these precautions have been outlined and promulgated and indeed are, by and large, the same kinds of precautions that health-care workers should have been taking all along. It turns out in those three, apparently, that two of the individuals may not have even been wearing gloves, and they were involved in percutaneous or invasive vascular therapeutic enterprises.

So, it is an important issue and one that should be carefully looked at.

Senator THURMOND. Now, from the knowledge to date, what would you say is the evidence to show as to the different ways in which AIDS can be transferred—very briefly. One would be through sex?

Dr. COHN. Yes, sir.

Senator THURMOND. And what are the others?

Dr. COHN. The IV drug abusers, the use of dirty needles where there is blood contamination and hence virus in that blood. And there is transmission through that route.

We still see a few cases of transfusion-related AIDS because one must remember the AIDS antibody test did not come into general usage until the spring of 1985. And that is one of the reasons for so-called "Look Back Program No. 2," that is to say, the program which relates to all those people who were transfused from 1978 to 1985, before the AIDS antibody test. So, we still see some cases of transfusion-related AIDS where the transfusion was given prior to 1985.

And the third route that I mentioned is the so-called "vertical transmission" unhappily, of course, from mother to child, where the mother is infected, where the mother may be HIV positive or indeed may have AIDS or may have had sexual contact with a risk group member or somebody that did have AIDS.

Senator THURMOND. I think it is important for the public to know just what you are talking about.

Dr. COHN. Thank you.

Senator THURMOND. And I appreciate your explaining that this morning.

Dr. COHN. Thank you, sir.

Senator THURMOND. I want to ask if you are having trouble getting nurses?

Dr. GRONVALL. Yes, sir. We have, particularly in the past 8 to 9 months, experienced shortages of nurses, particularly at individual medical centers. The competition for nurses has accelerated, and so not only we but community hospitals are experiencing a shortage of nurses.

Senator THURMOND. I understand that. What are you attributing this shortage to? I think all the hospitals are having trouble with getting nurses. Now, more men are going into nursing, aren't they?

Dr. GRONVALL. Yes, there are a number of men in nursing.

Senator THURMOND. Do they make very good nurses? I always thought a woman made the best nurse. [Laughter.]

Dr. GRONVALL. Men make excellent nurses, and women make excellent nurses. The total number of nurses being educated and prepared in this country, unfortunately, has declined in the past several years. So, the supply of new nurses has been reduced; and because many hospitals are experiencing new and more serious medical problems—AIDS is a good example—the need for nursing staff in hospitals is going up at a time when the supply is going down. That leaves a shortage problem, and so the hospitals begin to compete with each other to recruit and retain nurses basically out of a total supply that is inadequate.

Senator THURMOND. You said there is a demand for them today. I was wondering if you may have to pay them more.

Dr. GRONVALL. We are, sir. We have authority for special pay rates, and we have in recent months adopted special pay rates at a large number of medical centers as a way of improving our position.

Senator THURMOND. Thank you very much. We are very glad to have all of you with us. Again, I want to comment on the great job you have done in the health field.

Dr. GRONVALL. Thank you.

Senator THURMOND. I have another committee meeting, and I am glad I could be here.

Senator MURKOWSKI. Senator, there is a vote on at this time.

Senator THURMOND. Thank you very much.

Dr. GRONVALL. I appreciate your statement very much. Thank you, sir.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you very much, Senator Thurmond. I, too, want to take this opportunity on behalf of the minority to welcome you to this legislative hearing. I have a statement that will be inserted in the record.

[The prepared statement of Senator Murkowski appears on p. 142.]

Senator MURKOWSKI. I want to comment very briefly on a few points made by Senator Thurmond. As you are aware gentlemen, we on this side have been working toward initiating some type of an incentive program for nurses in areas where there has been difficulty in attracting and maintaining sufficient staff to care for veteran patients, including those with AIDS. I would also like to recognize the contribution and commitment of the professional nurses in the VA system who, I think, really bind together the quality care that our veterans are entitled to. As you know, I have introduced S. 713 which would provide a bonus of up to $20,000 for registered nurses who agree to work full-time in a specialty area or a geographic region for at least 3 years.

This incentive program has worked in the private sector. It would seem to me that this could save the Federal Government an awful lot of money by retaining quality nurses in areas where they otherwise would have substantial turnovers. It is meant to function as a retention tool.

I would hope that the panel would agree that the proposed incentive program has some merits. You are certainly free for the record to comment on any way to improve it; but I think the ability to retain skilled and experienced nurses in the VA system is of great significance.

One area that I am a little disturbed about is in the area of procurement. As a consequence, we have initiated some procurement reform that would encourage the VA to purchase medical and pharmaceutical supplies in a more cost-effective manner. As you know, gentlemen, Coopers and Lybrand related in their report completed last year that the VA purchased medical supplies in the local community, at a cost of 25 to 50 percent higher cost than through VA depots. One wonders why the VA does not receive the most favorable prices when purchases of nearly $1.2 million are annually made through the VA system. Evidently the recommendations of Cooper and Lybrand have not been totally implemented into the VA system.

To my knowledge, since the report was issued 1 year ago, not one system-wide program initiative to reduce procurement costs has been implemented. I would appreciate a comment on that. I gather we paid nearly $1 million for this study, which doesn't necessarily relate to a good or bad investment; but I think it at least warrants an explanation.

[Subsequently, the Veterans' Administration submitted the following information:]

The Veterans' Administration is pleased to have this opportunity to present to the Senate Veterans' Affairs Committee a summary of the many significant initiatives we have undertaken in the area of acquisition reform and improvements. We are also pleased to comment specifically on S. 631, the "Veterans' Administration Procurement Improvement Act of 1987."

With annual expenditures of over $4.1 billion for supplies and services, including construction, the VA operates one of the largest acquisition, inventory management and distribution activities in the Federal Government. As a leader in the Federal logistics arena, the VA not only supplies the largest health care delivery system in the free world but also has been delegated Federal responsibility for the centalized acquisition and management of medical care items for the entire Federal establishment. In this capacity, the Veterans' Administration procurement and supply operation serves the VA's 172 medical centers, 58 regional offices, 110 national cemeteries, 3 data processing centers, VA staff office requirements and over 1,650 other Government activities.

As a leader in the Federal procurement arena, the Veterans' Administration procurement and supply activities take pride in their operation and in their commitment to excellence and cost effectiveness in supply support. In pursuit of these ends, the Veterans' Administration not only has energetically pursued new initiatives to improve on cost and quality but also brought in an outside consultant firm, Coopers and Lybrand, to conduct a comparative study of VA and private sector procurement, contracting and distribution of medical supplies and nonperishable subsistence and assist us in critical examination of our acquisition program.

The Coopers and Lybrand study was begun in August 1984 and concluded in February 1986, at a total cost to the VA of approximately $871,000. After a very detailed analysis, the Coopers and Lybrand study found that the VA's current central distribution system, as compared to alternative private and Federal sector alternatives, was the most cost efficient acquisition strategy. For instance, the study found that had VA medical centers bought 28 comparable items from the Defense Logistics Agency rather than from the VA's supply depots in fiscal year 1985, the additional cost would have been $14.3 million. Similarly, the study found that the VA's present central distribution system, which currently has annual sales of over $306 million, resulted in cost savings in excess of 26 percent when compared to direct vendor delivery pricing.

Although the Coopers and Lybrand study endorsed the continuation of the VA's present cost effective central distribution system, it made 29 recommendations for further improvement of the system. Contrary to the statement in the hearing that not one of the Coopers and Lybrand (C&L) study recommendations has been implemented, we are pleased to report that of the 29 recommendations, 8 have been completely implemented and closed out, another 8 recommendations have been implemented but will be ongoing, and a systematic, coordinated implementation strategy is ongoing in the other areas. Highlights of this implementation progress are as follows:

1. C&L recommended that the VA institute a surcharge of 3.5 percent on purchases made from the VA by other Government agencies which average about $22 million per year. This recommendation was implemented April 1, 1987, and the projected annual income to VA is over $800,000. During the first month of implementation, the VA realized income of over $80,000.

2. C&L recommended that VA should add to the number of products currently managed within the VA's depot system. At the beginning of fiscal year 1987, the VA's three depots carried 1,552 line items. We set as our goal for fiscal year 1987 to add an additional 400 line items and each year will set additional goals. As of May 20, 1987, 192 new items have been added to our depot system resulting in a projected annual cost avoidance of $22 million. In implementation of another C&L recommendation and to facilitate adding new items to the depot, VA lowered its stockage criteria effective September 18, 1986.

3. C&L also recommended that the VA consolidate medical center requirements and purchase as a buying group. The VA already had an active Consolidated Procurement Program at the medical district level and has expanded this program. In fiscal year 1986, VA realize cost avoidance through this program of $1.25 million in procurement costs and a savings of $107,560 in related administrative costs; and for the first 6 months of fiscal year 1987, a cost avoidance of over $940,000 has been realized.

4. C&L recommended further that the VA expand the number of new medical supply and pharmaceutical items bought through the VA/DoD Shared Procurement Program. This program was instituted in 1978 and includes representatives from VA, Department of Defense, the Public Health Service, the Food & Drug Administration and General Services Administration. Its purpose is to consolidate purchasing and supply management of medical items on an interagency basis. Since initial implementation, cost avoidance achieved through consolidated buys has been over $130 million through joint usage of over 530 contracts. The shared procurement program also is being expanded to include contracting for commonly used medical equipment items. Thirty-eight (38) candidate equipment items have been identified thus far. It should be noted that in fiscal year 1986, the VA Marketing Center in Hines, IL, issued 603 delivery orders for high technology medical equipment at a cost of over $145 million. The VA accounted for $129 million of these purchases and other Government agencies purchased $16 million. Based on better pricing achieved through consolidating orders for this equipment, a cost avoidance of $39 million was achieved over basic list prices.

5. In yet another area, C&L recommended that the VA expand the number of pharmaceutical items procured through Non-Stock Special Order Contracts (or what is commonly referred to as the National Contracts Program). In fiscal year 1985, the VA aggregated requirements for 17 high volume IV solutions and awarded a national contract. Cost savings achieved were $4.5 million in fiscal year 1985 and an additional $4.5 million in fiscal year 1986. VA also aggregated national requirements for acetaminophen and acetaminophen compounds and reduced costs from $1 million annually to $500,000 annually. A similar approach was recently adopted with insulin and a national contract awarded on March 13, 1987. Expected annual cost avoidance from the national contract for insulin is expected to be $1.5 million.

6. C&L also recommended that the VA enhance its pricing information capabilities and this has been done by the hiring of a price analyst to manage this program at the VA Marketing Center at Hines, IL. Another recommendation was that the VA should reinstate the position of Traffic Manager and centralize control of the transportation function and this was implemented on January 18, 1987 with the recruitment of a Traffic Manager.

7. C&L further recommended that VA should modernize its Supply Automation System and this initiative will be funded in the amount of $2.229 million in fiscal year 1988. The VA is currently analyzing reengineering/redesign/off-the-shelf options for a major redesign of its LOG I system and the VA Office of Procurement and Supply recently completed a realignment of its ADP systems development staff to support this initiative. The Coopers and Lybrand study conservatively estimated that modernization of the 25-year-old LOG I system would result in immediate annual savings of approximately $4 million due to logistical efficiencies and the ability to reduce inventory holding costs. However, the VA anticipates that the additional supply management abilities afforded by a modernized ADP supply system will result in much more significant cost savings.

8. Perhaps most signficiantly, C&L recommended that the VA implement a national program to standardize medical supplies and pharmaceutical items used in VA medical centers. The VA already supports standardization through its depot system, consolidated procurement and centralized contracting functions. However, to significantly expand efforts in this area, the VA is formalizing a Medical Supply Standardization Program.

The above listings represent only a few highlights of the VA's implementation of the Coopers and Lybrand study recommendations. However, they are indicative of the major progress being made in these initiative areas. As can be noted, the VA already had implemented action in a number of these areas prior to the Coopers and Lybrand study, and has expanded significantly and built on these program improvements with major cost savings and avoidance being achieved.

The VA also has long been a strong advocate of the efficiencies and cost effectiveness of centralized contracting for volume buys. In recognition of the significant cost savings which can be achieved through centralized procurement, the Veterans' Administration has actively and very successfully pursued over the years strategies to reduce local procurement with the VA system. Through these efforts, overall local procurement in the VA system as a percentage of the VA's total procurement dollar has declined from 41.7 percent in fiscal year 1981 to 29.6 percent in fiscal year 1986; and in just the area of acquisition of drugs and medicines, the VA purchases 85 percent of the dollar volume of these products on a national basis. Our goal is to continue to significantly reduce the use of local procurement within the VA supply system where it is appropriate to do so. The VA also is a recognized leader in the field of enhancing the quality of its acquisition work force and fostering professionalism. Through our active contracting officer training program, formally called the Acquisition Training Program, the VA is seeing measureable increases in the quality of job skills, job performance and work outcomes in the agency's procurement work force.

This summary of VA actions and activities in the area of acquisition reform and improvements is a lengthy way of saying that we are committed to improvements and we are committed to innovations which will enable the VA to ensure the provision of high quality supply support in the most cost effective and efficient manner possible. We are proud of our past accomplishments and will continue to vigorously pursue management and productivity improvements which will enable our procurement and supply program to achieve its mission even better.

In this regard, we appreciate the intent of S. 631, the "Veterans' Administration procurement Improvement Act of 1987" to enhance and support the process by which the VA procures medical and pharmaceutical supplies. Since the VA is already implementing a program to standardize these procurements, however, we do not support enactment of this legislation.

S. 631 would require the VA, within 3 years of its enactment, to develop and fully implement an Agency-wide plan for the standardization of all medical supplies and pharmaceuticals procured by the VA; require VA medical centers to purchase these items through national contracts; require medical centers to enter into contracts with local vendors in certain situations; and require medical centers to report annually to the Administrator of Veterans' Affairs on all medical and pharmaceutical items or supplies procured annually by the medical center under a local contract.

One goal of the VA is to ensure the effective and efficient delivery of medical services to its patients. The VA views standardization as a way to enhance that goal and is implementing such a program now. At present, for the initial pilot test of the standardization program, the VA is reviewing 32 medical and pharmaceutical items for possible standardization. The VA also is preparing a circular to establish a policy of analyzing and identifying items for possible standardization and to ensure that this process is ongoing. With issuance of the circular, the standardization program will be "institutionalized" and be a continuous part of VA procurement decisions. We believe these efforts are indicative of the VA's commitment to improve the process by which it procures medical and pharmaceutical supplies, and that legislation of this nature is unnecessary.

One area in which legislation action would be most helpful, however, would be to authorize the VA to use multiyear contracts. Although S. 631 does not address this issue, enactment of such a provision would provide the VA with significant cost savings in contract administration, supplies and equipment. The Office of Management and Budget has advised that there is no objection to multiyear legislative authority in recognition of the economies it could achieve and its value to furthering the VA's standardization effort. We would ask the committee's consideration of such a proposal.

Senator MURKOWSKI. Another concern I have, and it happens to be perhaps a little more regional, relates to beneficiary travel. As you know, in my State we don't have VA hospitals. We depend on the private sector. Because Alaska's geographical area is one-fifth the size of the United States, we move people in so they can receive medical care. The VA program in my State has been tightened up substantially, which I support; but we find cases now where people must fly to Anchorage. The costs are very high and there is absolutely no money to transport them. I understand that about $100 million, in addition to staff costs at each medical center, was being spent annually to provide that benefit. The VA, in implementing new regulations, is very limited in this area.

In the statements of certain witnesses there is a general reference to the private sector, vis-a-vis the VA, in the sense of the role of the private sector in providing services to veterans. I personally don't subscribe to the theory that veterans who may run or work in many of our Nation's private corporations and small buinesses are insensitive or incapable of serving veterans. I don't think that is the case.

But there is a theme in some of the testimony that implies that it is an "us against them attitude," and I think you would agree that it really doesn't serve much of a purpose.

I am sure you are aware of the GAO report which Senator Cranston and I released yesterday. This is obviously not the place to respond to it; but at an appropriate time, we would appreciate your comments. I have just one question. We do have a vote on. Senator Mitchell, have you voted?

Senator MITCHELL. No, I haven't, Senator.

Senator MURKOWSKI. All right. I am still giving my opening statement, and I understand Senator DeConcini will be here shortly. Senator Cranston just left, so it may be a few more minutes. I am going to be leaving in just a couple of minutes; but I thought if you wanted to vote and come back?

Senator MITCHELL. No, I won't be able to. So, why don't you go ahead and finish?

Senator MURKOWSKI. All right. I will try to be very brief. There has been some discussion about AIDS. It is my understanding that, in one of our hospitals in New York City—a hospital of about 600 beds—nearly one-third of the patients are being treated for AIDS. That in itself is rather alarming; the degree of accuracy, I don't know. You can comment on that.

But we have a growing problem, and I don't think it has really sunk in as far as just what this means in health-care costs.

I understand that the VA reimburses its hospitals with $40 to $45 a day for treatment of an AIDS patient. I am told that the actual costs of care for AIDS victims is running from $300 to $800 a day. Can you tell me how you are trying to plan for this reality that appears to be on us? Obviously, you are going to have to have more help from the Government. This is something that I am sure, 4 or 5 years ago, you had not planned for. You have probably been looking at how you take care of the aged veteran.

Now, you have another obligation. Can you comment a little on that?

Dr. GRONVALL. I would be pleased to, Senator.

Senator MITCHELL. Are you going to ask a series of questions?

Senator MURKOWSKI. I am asking just one question and I am leaving.

Dr. GRONVALL. I will give you a quick answer then. The AIDS epidemic is a major crisis that faces us and the Nation. We have attempted to predict as accurately as we can the growth of the number of veterans sent to us for care. By the end of this year, we will have seen and treated over 3,000 veterans with AIDS. Our experience is that each of those patients during the course of a year costs us about $25,000 to treat.

Senator MURKOWSKI. A year?

Dr. GRONVALL. Yes. The typical veteran may live 2 to 2½ years and, during the course of that time, our cost experience is about $25,000 a year. The allowance or allocation to the hospital depends on which other kind of disease complication the AIDS patient has; and so, we make an allocation using the DRG for that particular complication.

Because the AIDS cases are more expensive than our allocation formula, a year ago we made a special additional allocation to each of the hospitals that had more than 10 cases.

Senator MURKOWSKI. Because of the constraints of time—I want to accommodate Senator Mitchell—what I would ask you to do is respond in my absence and I will defer to Senator Mitchell. I would ask the staff people to make notes for me. Senator Mitchell?

OPENING STATEMENT OF SENATOR MITCHELL

Senator MITCHELL. Thank you very much. I apologize to the witnesses because we now have less than 5 minutes left to go vote. So, I will have to leave immediately. I do ask that my statement be placed in the record.

I am serving on the Select Committee investigating the Iran Contra matter. As a result of that I have been unable to attend hearings and meetings of this and other committees as I would like. But I wanted to especially express my interest in the health-care issues. I have a particular interest in this area as I serve as chairman of the Senate Health Subcommittee on the Finance Committee.

I am a cosponsor of some of the bills that will be considered here today. And I am especially concerned about the problem of beneficiary travel, coming from a State which is large in land area and sparsely populated. It has caused a real problem to us.

I am pleased that the Chairman and ranking member have directed the staff to develop a bipartisan alternative to that.

I thank you gentlemen for coming here. I apologize to you again for the inconvenience of our having to come and go, but I guess you have come to understand that is an unfortunate part of our process. Senator Cranston has asked that the Chief Counsel follow up with some questions while awaiting Senator DeConcini's return. Thank you very much.

[The prepared statement of Senator Mitchell appears on p. 147.]

Dr. GRONVALL. Thank you.

Mr. STEINBERG. Thank you, Senator Mitchell. We have a number of questions regarding S. 1136, which Senator Cranston has introduced on behalf of the Administration; Mr. Ivers or Mr. Rudd may want to respond to these.

Under current law, disciplinary boards are appointed by the Chief Medical Director, thereby removing local officials from direct involvement in those proceedings. S. 1136, in effect, would create a situation as to "lesser disciplinary actions" in which the same local officials who would bring charges against an employee would be the ones to determine whether the employee should be subject to adverse action and also what disciplinary penalty should be proposed.

It seems to us that this would create an inequitable process. Why do you think that it would be fair to have the same officials be the charging party, the prosecutor, and the convening authority?

Dr. GRONVALL. Let me ask Mr. Ivers to comment first and then Mr. Rudd.

Mr. STEINBERG. Thank you.

Mr. IVERS. I am frankly not sure that that is the full extent of that proposal. What that does is to decentralize, to a larger degree than we presently have, the ability to determine disciplinary actions and to decide disciplinary actions. Right now, it is all centralized, and it is a very cumbersome process. It doesn't eliminate the ability of those individuals subject to the disciplinary process at the lower level from appeal to the central office and appeal to the Administrator.

Mr. RUDD. I might add that that parallels the title 5 personnel system; and as Mr. Ivers indicates, the employee of course would retain the right of appeal.

Mr. STEINBERG. Under the title 5 personnel system, employees also have a parallel right to go to the MSPB, do they not, and seek independent——

Mr. RUDD. Not for those lesser actions, sir.

Mr. STEINBERG. For the suspensions that are included in your proposal?

Mr. RUDD. For suspensions of 14 days and less and reprimands and admonishments, they do not have the right to appeal the merit system protection.

Mr. STEINBERG. So, you are suggesting that the same situation would prevail that prevails under title 5?

Mr. RUDD. Essentially, yes.

Mr. STEINBERG. Would you provide us with a more detailed written response on that issue, comparing title 5 procedures to those you are proposing with respect to title 38 for these so-called lesser types of disciplinary actions?

Mr. RUDD. Yes, sir.

[The information submitted by the Veterans' Administration appears on p. 258.]

Mr. STEINBERG. Also, in that same bill, you have proposed that the authority to appoint the members of the disciplinary boards under section 4110 be delegated to the Medical Center level rather than to remain at the Chief Medical Director level as at present, so that the effect, it seems to us, would be that the appointing authority more often than not would be part of the same management team bringing the charges against the employee in question. Is that a correct summary of what the effect of that delegation would be?

Mr. RUDD. I believe the bill provides for the Chief Medical Director to have the authority to delegate that to lesser levels within the agency, not necessarily to the same official who is proposing the action.

Mr. STEINBERG. So that delegation may go to a regional official?

Mr. RUDD. It might go to a regional official. It might go to Mr. Lindsey, the Director of Operations, for example.

Mr. STEINBERG. If we were to propose an amendment to permit delegation as long as delegation were not to the Medical Center or other facility director where the charge originated, would that be acceptable to you?

Mr. RUDD. Certainly in my opinion, that would be acceptable. Mr. Ivers may want to speak to that as well.

Mr. Ivers. Legally, it would certainly be acceptable.

Mr. Steinberg. I know, but would that be an acceptable modification from your standpoint in order to receive the additional flexibility you desire in terms of delegation?

Dr. Gronvall. It seems to me that that is something that we perhaps ought to sit down and look at. Clearly, the principle that the person bringing charges should not be the person who selects the board to review the charges is unexceptionable. It seems to me there may be situations in which the Medical Center Director is in fact the best person to select the members of the disciplinary board.

And the way you described your amendment suggested that the delegation could not ever be made to the Medical Center Director; and it seems to me that that is a question we ought to sit down and look at and reply in writing.

[Subsequently, the Veterans' Administration submitted the following information:]

> We propose to maintain the practice of having the decision official appoint the Board in each case, as envisioned in the present section 4110. Since in all cases the decision official would continue to be a high level official than the proposing official, we would be able to ensure a high degree of impartiality in the Disciplinary Board and decisionmaking processes. Only if the Medical Center Director were delegated authority to issue a decision following Disciplinary Board action would be or she be delegated the concomitant authority to appoint the Board. In developing delegation authorities, consideration would be given to both the nature of the action and the category of empolyee involved, and will preclude any official who has proposed charges from appointing the board and from acting on its recommendations.

Mr. Steinberg. That would be fine. There will certainly be a strong disposition on our part not to permit that apparent conflict of interest so that, in responding, we would appreciate it if you would amplify those extraordinary circumstances where you think appointment by the Medical Center or Outpatient Clinic Director would be necessary.

Dr. Gronvall. I don't have any incidents, and that was not an answer. It was just a reflection on the way you defined the suggested amendment.

Mr. Steinberg. Further, with respect to S. 1136, would it not be possible that disciplinary actions that are deemed serious enough to occasion suspensions of up to 13 days or transfers between VA facilities or reassignments within VA facilities and demotions not affecting grade or pay could be of such a serious enough nature to have a lasting repercussion on an employee's career advancement?

Mr. Rudd. I would imagine that any disciplinary action for a high level official could have repercussions for his future career. Yes, I would agree with that.

Mr. Steinberg. Would not that situation then affect the employee's property interest in a substantial enough way—that is, his property interest in his job—to merit the kinds of due process protections afforded by a section 4110 disciplinary board?

Mr. Rudd. I think the legislation again proposes that the appellate right to the Administrator would be retained as is the case in those more serious actions.

Mr. Steinberg. I was talking more about the hearing itself or initial administrative stage, rather than the appellate stage.

Mr. RUDD. Don, do you have any response to that from the standpoind of the case law?

Mr. IVERS. My opinion is the same. Due process protections are available in those situations as they would be in the situation that exists now in those more serious disciplinary actions. It is simply a matter of at what level the due process protections begin to attach the administrative or mechanical aspects of the process. While granted they do not have the same adversarial proceeding available to them, they have the same appellate rights. They have the same right to notice, and they have the same right to appear; but it is a reduced type of hearing.

Mr. STEINBERG. Specifically, what rights would employees not have if S. 1136 were enacted into law that they now have under section 4110?

Mr. IVERS. The only one that I can see at that level would be the full-blown adversarial hearing. They still have a right to be heard. They still have a right to submit——

Mr. STEINBERG. Their right to be heard would be with respect to written submissions?

Mr. IVERS. No.

Mr. RUDD. No, sir. It would be before a grievance examiner as opposed to a full disciplinary board, but the individual would retain right of representation and be able to call witnesses and so on.

Mr. STEINBERG. But no right to cross examine, as it were, in an adversarial sense whoever was making the charge against them?

Mr. RUDD. I think the bill contemplates that we would develop procedures for those lesser actions. What our discussions have been thus far are something paralleling the existing grievance procedure. And you are right about that, about no right of cross examination, although certainly it would be possible to build that into the procedure.

Mr. STEINBERG. Would you give us further amplification on that? We would very much like to work with you—as we had committed in the past that we would be willing to do—to try to develop modifications in your proposal that would make it more acceptable from our standpoint.

Finally, on that point, it is somewhat unclear, if you take action on those items you have mentioned—including possibly incorporating adversarial aspects such as cross examination— what would the difference be between that new grievance-like procedure and the section 4110 board? Would one of the differences be the makeup of the board itself?

Mr. RUDD. Yes, and also section 4110 now calls for a screening committee which is similar to a grand jury type of activity. We would avoid that type of procedure.

Mr. STEINBERG. It would be very helpful when you get back to us if you could give us a side-by-side comparison of what exists for section 4110 and what could exist under this grievance procedure from appointment—screening procedure—and the actual proceeding of the disciplinary process. Then, we would be able to work with you and with the minority to develop an approach to give you more flexibility in this area which we would like to be able to do.

Mr. RUDD. We would be most happy to work with the staff.

Mr. **Steinberg**. Thank you.

[The information submitted by the Veterans' Administration appears on p. 258.]

Mr. **Steinberg**. Two of the union witnesses today—the AFGE and the NFFE—express concerns about the impact of shifting employees from title 5 to the so-called title 5/title 38 hybrid categories. Specifically, they are talking about the shift that we made in Public Law 98–160 to the hybrid category for certified or registered respiratory therapists, licensed physical therapists, and licensed practical and vocational nurses. They are also talking about the proposal in S. 1195 to do the same for the new categories.

Their particular concern is that it appears that these "hybrid" employees have not remained under the title 5 provisions with respect to matters involving grievances and disciplinary matters. We were surprised by that statement because we thought it was clear at the time of the creation of the "hybrid" category that Congress intended for those employees to remain under title 5 for such matters.

Specifically, the joint explanatory statement of the two Committees on Veterans' Affairs explaining Public Law 98–160 stated: "The committees note that it is not the intent of the provisions of this legislation relating to the three DM&S occupations involved to diminish or impair in any way the rights and protections guaranteed the employees in those occupations under the express provisions of chapter 71 of title 5 relating to Federal labor-management relations."

In light of this statement, do you see any basis for the apparent confusion about the status of the "hybrid" employees in terms of personnel protections and labor-management relations?

Mr. **Rudd**. I think there is a basis for confusion. We do not deny those hybrid employees full access to appellate procedures under title 5 for those aspects of their employment that fall under title 5; but at the current time, certain aspects of their employment like appointment and promotion fall under title 38, and that is where the rub is.

So, for those actions, we have taken the position on the advice of counsel that they do not have access to arbitration procedures because we are taking that position across the board with respect to title 38 employees. It sounds confusing, I am sure.

Mr. **Steinberg**. Don, is that the position that the General Counsel has taken?

Mr. **Ivers**. That is correct. That is the interpretation that we placed on the statute. There is also some additional confusion that has been thrown into this situation by at least one ruling by the MSPB. That is in the process of changing, or being changed through the normal——

Mr. **Steinberg**. But you are not in agreement with that ruling of the MSPB?

Mr. **Ivers**. Not the current one. No.

Mr. **Steinberg**. Would you provide more detail for the record on that situation and also a copy of your opinion with regard to the matter that Mr. Rudd just amplified? It may be the desire of the committee to clarify that matter in order to achieve what it thought it was achieving at the time of enactment of Public Law

98-160 and what we believe the joint explanatory statement of the two committees rather unequivocally set forth as the congressional intention.

We would like you to be on notice that at least our beginning presumption in this area is that we will attempt to make the law clearer that title 5 protections and the existing labor-management relation situation is to prevail as to all aspects of the "hybrid" employees' employment, rather than only the title 5 aspects.

Of course, if you disagree with that proposal, as a matter of policy, we would like to have you tell us that and give us your reasons.

Mr. RUDD. Yes, sir.

[The information submitted by the Veterans' Administration appears on p. 264.]

Mr. STEINBERG. With respect to your testimony on section 4(a) of S. 6 relating to providing readjustment counseling eligibility for active duty members who served during the Vietnam era, you note that your readjustment counseling program is effective and could benefit active duty members; but you oppose that provision, noting that the Department of Defense has that responsibility, but also noting that there could be sharing agreements entered into between the VA and the Department of Defense under which DOD would reimburse the VA for the provision of readjustment counseling services to active duty members.

I recall this same dialog 2 or 3 years ago with Dr. Brown, but there is nothing like history repeating itself. Has any DOD entity ever, to your knowledge, proposed entering into a sharing agreement with respect to readjusgment counseling services?

Dr. GRONVALL. I don't know the answer to that, and I am not sure whether someone here today does know it.

Mr. STEINBERG. If you would provide that for the record?

Dr. GRONVALL. I would be pleased to.

Mr. STEINBERG. And whether or not the VA itself has ever proposed one.

Dr. GRONVALL. I don't know the answer to that. I would be pleased to supply it.

[Subsequently, the Veterans' Administration furnished the following information:]

There does exist one such sharing agreement under which VA provides readjustment counseling services to unilitary members (see above). We are not aware of DOD facilities otherwise having proposed such agreements.

Mr. STEINBERG. With respect to the possibility of that resolving the problem, The American Legion makes a very good point in its testimony about how unlikely it is that such agreements would work. On page 2 they say that "were DOD to become involved in supporting such services, many career personnel would not seek such assistance for fear of jeopardizing their advancement because of receiving what could be construed as psychiatric treatment."

Would you agree that this concern is a legitimate one and one that could be a real impediment to DOD paying for such services?

Dr. GRONVALL. I have not seen their testimony, of course, and I would want the advice of our Vet Center staff on that question and then supply a comment to you.

Mr. STEINBERG. All right. You understand the concern that the Legion expressed and our concern with respect to the psychological situation that might prevent an active duty member from making known to his superiors in the service that he was in need of, in his opinion, readjustment counseling services and was seeking those services?

Dr. GRONVALL. Yes, I surely understand that. As I say, I would like the advice of our readjustment counseling people and then supply a comment.

[Subsequently, the Veterans' Administration furnished the following information:]

It is likely that anonymity would be an important matter for active duty career personnel who contemplate any form of psychological counseling or mental health services.

Mr. STEINBERG. And would you further agree in that regard—just to conclude this—that there would be no way for sharing agreements to work if the agreement specified that the DOD would reimburse the VA unless DOD knew that such services were being sought by the particular service person involved? That is, there would have to be an identification of that service person?

Dr. GRONVALL. I would surely assume that. I suppose I could create a hypothetical situation in which confidentiality might be maintained and we could document the number of active duty personnel receiving the service. I think that would be very hard to accomplish.

Mr. STEINBERG. That was the burden of the questioning with Dr. Brown about 2 or 3 years ago on that same issue; and we said that, if you can get DOD to agree to do it based on your head count, that would certainly be very desirable and the committee would be very supportive of that. And I don't recall anything having occurred in the last 3 years to suggest that you were able to work that out with the Department of Defense; but again, that option is certainly open, and we welcome your views on that possibility.

Dr. GRONVALL. Good. I will surely look into it. It may well have been further explored; I am just unaware of it.

Senator DECONCINI. Doctor, thank you. I would like to have my opening statement inserted in the appropriate place.

[The prepared statement of Senator DeConcini appears on p. 150.]

Senator DECONCINI. I have just a couple of quick questions, and I am glad that I could get back for them. Does the VA health system have any child care systems or programs now in place?

Dr. GRONVALL. Yes, sir. A number of our Medical Centers have made local arrangements for child care where it assists staff——

Senator DECONCINI. In house? On the premises?

Dr. GRONVALL. Yes, sir.

Senator DECONCINI. And are those proprietary or are they operated by the VA or by the employees?

Dr. GRONVALL. I believe we have instances under all of those headings. Mr. Lindsey, can you help me?

Mr. LINDSEY. Yes, that is correct.

Senator DECONCINI. You do have that?

Mr. LINDSEY. Yes.

Senator DECONCINI. Could you provide us a statement as to what this entails? And I presume that you are satisfied that you don't need authorizing legislation to proceed with that?

Dr. GRONVALL. We already have it. We believe we have the authority to have such programs. We have a number of them, as I say, under different auspices and have policy statements and guidelines within which they have been worked out at each of the Medical Centers that has one.

Senator DECONCINI. Thank you very much. Do you have, just quickly, how many do have them?

Dr. GRONVALL. No, sir.

Senator DECONCINI. All right. You can supply that for the record.

Dr. GRONVALL. We will supply that for the record.

Senator DECONCINI. And the nature of the operations, whether they are infant care or mid-level and how they are financed and how they are paid for?

Dr. GRONVALL. We would be pleased to give a general description with the numbers and the auspices and the guidelines.

Senator DECONCINI. Thank you very much. And would you include the locations?

Dr. GRONVALL. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

There are 15 active child care services, centers and five planned centers associated with Veterans' Administration Medical Centers. The active child care services centers are located at VA Medical Centers: Togus, ME; Northport, NY; Brockton/West Roxbury, MA; Albany, NY; Wilmington, DE; Perry Point, MD; Ann Arbor, MI: North Chicago, IL; Hines, IL; Dayton, OH; Knoxville, IA; Martinez, CA; Long Beach, CA; and New Orleans, LA.

Those under development are at San Francisco, CA; Tucson, AZ; Tuscaloosa, AL; Dublin, GA; and St. Louis, MO.

These centers serve approximately 684 to 705 children from infancy through school age.

These are provided through several arrangements (seven leased to nonprofit groups, others to independent employees groups, union, etc.).

Of those responding, 12 reported that the services were located on VA property with only one reporting an off-premises center.

The programs were initiated as early as 1975 with two presently under development.

Most report that the funds are raised by the Boards of Directors from tuition and fundraising efforts such as cake sales, etc.

Senator DECONCINI. Let me go into one other area. What information must the Veterans' Medical Centers document to justify the need for special rates?

Dr. GRONVALL. Let me ask Mr. Lindsey, our Director of Operations, to comment on that; and Mr. Rudd, the Personnel Director, may want to comment also.

Mr. LINDSEY. Normally, the Medical Center which is experiencing the problem will do an analysis within the local community to determine if the rates that they are paying the nursing staff are comparable. If they feel they are at a disadvantage, then it is the burden of the Medical Center to come in with a request for special pay rates. When those special pay rate requests come into the Central Office, they are reviewed by the Office of Personnel; they go through an analysis of that. Then, when they have completed their work, they bring that down to the Department of Medicine and Surgery where Operations looks at that, discusses the rates with the Medical Center, reaches agreement with the Medical Center that the proposed special rates will solve their problem; and then there is a consortium meeting, and this meeting is held, by the way, once a week because of the situation.

An agreement is reached, and then, for those special rates for which the Chief Medical Director has authority, they are presented to him; and for those special rates where OPM concurrence is required, they are sent by the Administrator to the Office of Personnel Management.

Senator **DeConcini**. Thank you. Mr. Rudd, would you care to comment?

Mr. **Rudd**. Just that the analysis done locally would include comparable rates being paid in the community, staffing data, turnover rates, length of vacancies—items of that nature are what go into that analysis.

Senator **DeConcini**. Thank you.

Dr. **Gronvall**. I might just add, Mr. Chairman, that as of about 2 weeks ago, we had 368 special rate agreements that were approved and in force. These dealt with the salaries of about 10,500 employees including nurses, pharmacists, and physical therapists.

Senator **DeConcini**. Thank you. I will yield to the Senator from Florida for his questions.

Senator **Graham**. Thank you, Mr. Chairman. Doctor, in your testimony, you talked about the suggestion of extending home health-care services to a broader range of veterans. It is my experience in visiting some of the veterans' hospitals in my State that the primary use of home health-care services currently is in the post-hospitalization period. Would you anticipate that home health-care services might be offered in a preadmission state in order to reduce the need for institutional care?

Dr. **Gronvall**. I think that I can give only a very general answer to that, and I would have to look to someone else who might be more familiar with the details of our programs; but we are exploring a number of ways in which services provided at home or out of the hospital in the least possible costly way can assist people—veterans—to avoid the need to come into the hospital or where a veteran, for one reason or another, has difficulty coming to a clinical hospital.

So, as a general answer: Yes, we would be anxious to explore and do have programs exploring ways in which we can use home health-care services as a follow-up to hospital care or as a way to avoid more expensive kinds of care in our clinics or hospitals.

[Subsequently, the Veterans' Administration furnished the following information:]

HOME HEALTH CARE

Home health care is used only as a program of follow-up to hospital care because of the limitation of the statutory authority under the outpatient section of title 38. In fiscal year 1986, 89 percent of the patients admitted to Hospital Based Home Care (HBHC) were discharges from the hospital with eligibility as post hospital care patients.

Senator **Graham**. As a general proposition, what is your sense of the opportunity for preventive measures, including home health-care services, as a means of reducing the current level of intensity of utilization of your institutional care?

Dr. **Gronvall**. Let me make a general comment, and then I would like to turn to Dr. Howard Cohn because he has spent a great deal of time developing the various preventive health-care activities of the VA. Preventive health activities are important. They help prevent disease; they find disease at an early stage as a result of screening programs. As a generalization, I believe the experience of active screening programs is that they don't end up resulting in a direct reduction of the need for hospital care.

They tend to turn up additional people with problems that do need treatment of one form or another. But I would be pleased to let Dr. Cohn make a more detailed comment.

Dr. **Cohn**. I would just add that, based on our experience with the former prisoner of war population—and you may be aware, Senator, that we have a medical evaluation program for all former POWs. In any case, as a result of a protocol examination for that particular subpopulation of veterans, we discovered illnesses in approximately 15 to 20 percent of that group which necessitated their needing continuing health-care.

So, just as Dr. Gronvall said, generally those screening activities raise the need for additional and continuing health care. We do have a preventive health-care program generally in the system, and again, as Dr. Gronvall alluded to; and what we have chosen to do is emphasize different arenas or different areas of prevention on a per annum basis.

For example, in this current year, we are emphasizing colorectal screening as a preventive activity. Obviously, we have ongoing programs in terms of hypertension control; there are any number of specialized centers that indeed uncover and follow patients with hypertension. And indeed, a whole variety of programs: smoking cessation programs; our entire alcohol and substance abuse programs can certainly be looked upon as having a heavily preventative aspect to them as well.

And as you know probably, the U.S. Public Health Service—again, active in this arena—has identified, if my memory serves me correctly, no less than 100 different preventative health-care activities. So, it is a broad area that can obviously have a significant impact on costs and resources.

Senator **Graham**. Thank you.

Mr. **Steinberg**. Does that conclude your questioning? You are in the chair, Senator Graham. You can dismiss this panel and we can call our next panel if that is agreeable to you?

Senator **Graham**. All right. I am sorry that I have to dismiss you, after not having had the full benefit of having heard you—— [Laughter.]

Senator **Graham**. But I appreciate your participation. Thank you very much.

Dr. **Gronvall**. Being dismissed with thanks is never something that you should apologize for to a panel of witnesses. Thank you, sir.

Senator GRAHAM. If the next panel could stand ready, we have just been called for a vote. We will take a recess until such time as that vote has been completed. Thank you.

[Whereupon, at 10:27 a.m., the hearing was recessed.]

[The committee reconvened at 10:29 a.m.]

Senator DECONCINI. Ms. Lloyd, we are very pleased to have you here, also Dr. Naylor, and Dr. McCarthy. If you will summarize your statements, please proceed.

STATEMENT OF E. ELAINE LLOYD, PRESIDENT, NURSES ORGANIZATION OF THE VETERANS' ADMINISTRATION

Ms. LLOYD. Thank you. NOVA thanks you, Mr. Chairman, for the opportunity to present the views of nurses working in the VA system. We have submitted our written statement, without having studied the final draft of S. 1195; and today we will comment on the provisions and briefly summarize our written statement.

NOVA has no objections to the first two provisions of the Personnel Act. The third provision, increasing the service obligation in the VA scholarship program, will need careful monitoring to assure that it does not become a deterrent to participation. Provision 4: Working nights, evenings, and weekends are some of the hardships of being a nurse. Additional pay for these odd hours is one way to attract nurses to work these shifts. Failure to pay premium pay for Saturday, which is part of the weekend, is a glaring omission.

In 1986, 41.5 percent of the VA's reported that they were at a disadvantage in comparison to other facilities when it came to paying weekend premium pay. This failure to be competitive is astonishing to NOVA, as I am sure it is to you, Mr. Chairman, when the Congress in Public Law 97-251 authorized the VA to institute the Baylor Plan and Saturday premium pay.

To date, NOVA is unaware of any VA using this provision. Therefore, we urge support of Senator Cranston's legislation, and the success of this historic step is dependent on the assurance of adequate funding being budgeted and allocated.

Tuition reimbursement. With 70 percent of our nation's hospitals reporting they pay tuition reimbursement and 77 percent of the VA hospitals reporting that they were at a disadvantage because they did not, the time has come for the VA to have a tuition reimbursement program for nurses. And we thank the members of the committee for including this provision. NOVA supports this provision with the following reservations. A tuition reimbursement program that requires 2 years of full-time employment prior to eligibility is an outstanding retention tool, but will do very little for recruitment.

We also believe tuition reimbursement should be tied to a satisfactory performance level, rather than superior. A workable tuition reimbursement program will give a loud and clear message from the VA and the Congress to the VA nurse that we have a vested interest in your future and we care about your professional growth.

NOVA strongly supports the Chiefs of Nursing Service or their designee be on policymaking and fiscal committees. Decisions made in these committees will be better decisions with the participation of the chief nurse, and we hope their voices will be heard.

S. 713. The bonus program as proposed would have a positive effect on nurse recruitment in the VA, but a bonus bill of this magnitude would have a significant negative impact on our nurses if it did not address some additional compensation package to include nurses presently employed. Many have already indicated they would quit and wait to be recruited with a bonus.

I would like to address also two other issues that are of great concern to us, those of salary rates and workloads. Only 54 percent of VA facilities report that salaries are comparable to or greater than those in the local non-Federal medical facilities. NOVA asserts that the special salary rates have not achieved comparability for the reasons we have listed on page 8 of our written statement.

Assuring that nurses on special salary rates also receive the Federal employee cost-of-living adjustment would prevent the severe discrepancies between the VA and the private sector.

How can the VA be expected to solve its recruitment and retention problems unless pay comparability is closer to 100 percent?

Workloads. The VA's identified shortage of 8,200 nurses is felt even in hospitals that report no recruitment and retention problems. Nurses report unrealistic workloads caused by unrealistic allocations of nursing staff. As one of our NOVA members, a registered nurse and a Vietnam veteran from Pennsylvania, wrote so poignantly about his hospital's workload: "Presently, we are being impacted with the following buzzwords: 'productivity,' 'time management' and 'utilization of human resources.' I find myself wanting to scream: 'Hey, we are taking care of people, you know, human beings.' We aren't manufacturing computers or airplanes. We are caring for individuals. How are we going to attract the bright, young, caring people our profession so desperately needs as we become a sweatshop industry?"

NOVA exhorts the VA and the Congress to take steps to increase staffing levels and to assure that VA salaries for nurses are comparable to the private sector.

Senator DeConcini. Thank you. I am sorry we are suffering under time constraints, but your full statement will appear in the record, and we appreciate the summary.

Dr. Naylor?

[The prepared statement of Ms. Lloyd appears on p. 278.]

STATEMENT OF DR. MARY D. NAYLOR, ASSOCIATE DEAN AND DIRECTOR OF UNDERGRADUATE STUDIES, SCHOOL OF NURSING, UNIVERSITY OF PENNSYLVANIA

Dr. Naylor. Mr. Chairman, I am also pleased to have the opportunity to address the committee on an issue of vital importance to the health of our veterans and all the people in this country of the critical shortage of qualified nurses.

The acute shortage of nurses, evident in many hospitals, nursing homes, and home care agencies today, is compounded by dramatic declines in nursing school enrollments as traditional candidates turn to other options. I have submitted a detailed, written statement to be included in the record of this hearing.

All types of basic nursing programs—baccalaureate degree, associate degree, and diploma—are reporting significant decreases in new student enrollments. For example, baccalaureate programs reported a 17 percent decrease in enrollment from the fall of 1984 to the fall of 1986.

The anticipated number of graduates from bachelor's programs in nursing in 1990 is approximately 11,500, a number significantly less than the 23,000 individuals expected to acquire a medical degree that year. The national pool of high school and college men and women indicating an interest in nursing hit a record low in 1986. Data from the Educational Testing Services in Princeton, New Jersey reveal that the quality of those students who are interested in nursing has dropped markedly. According to a UCLA survey of freshman attitudes and values, the declining popularity of nursing as a career is associated with the migration of students away from human service professions to business.

Money, status, and power are the values freshmen are seeking. Popularity of values associated with nursing, such as altruism and concern, are waning. These major changes in the current and future supply of nurses are occurring at a time when the need for highly sophisticated, caring nurses is more urgent than at any other period in our history.

Trends indicate that by the year 2000, there will be approximately one-half as many undergraduate, master's and doctorally prepared nurses as needed. This represents a deficiency of 619,000 nurses prepared at the undergraduate and graduate levels.

If the decline in student interest continues, this Nation will experience a nursing shortage of dangerous proportions. The solutions to the current crisis, however, must depart from past experiences. Turning this enrollment picture around is dependent upon enhancing the work environment and reward system for nurses and promoting the public's understanding of nursing as a respected and desired field of endeavor.

A large segment of the stream of entrants into nursing must be diverted away from technical programs into the professional sector by maximizing on the opportunities for baccalaureate and graduate degree preparation currently available. Action must be taken to recruit the best and brightest of our high school and college students to nursing.

Further, we must enhance the capability for already practicing nurses to further their education through such mechanisms as tuition reimbursement programs as a means of improving the quality of care provided to the American public. Mr. Chairman, today and in the foreseeable future, this Nation will face multifaceted problems in caring for our elderly, for the chronically ill, and for those Americans who have limited access to health care.

Research has demonstrated that nurses can provide cost-effective care to many segments of the population: young mothers with low birth weight infants, young men and women with AIDS, individuals with chronic mental and physical illnesses, and the frail elderly and their families.

The nursing profession must continue to attract the best and brightest to fully contribute to our quest for excellence in health care. The health of Americans requires intelligent, sophisticated, and caring nurses to offer services at the lowest cost and highest quality. Legislation must enable this to occur. Nursing is a national resource, and properly used can significantly help to solve the health problems we face today and anticipate tomorrow. Thank you.

Senator DeConcini. Thank you very much. I would like the record to show at this point that, Dr. Gronvall and many members of our previous panel, that you have remained with us today. That is most encouraging. I know you have other places to go and things to do; and it is encouraging that you can witness some of this testimony with us. I appreciate that very much.

Dr. McCarthy?

[The prepared statement of Dr. Naylor appears on p. 289.]

STATEMENT OF DR. SHEILA McCARTHY, DIRECTOR OF NURSING, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, AND PRESIDENT-ELECT, AMERICAN ORGANIZATION OF NURSE EXECUTIVES

Dr. McCarthy. Mr. Chairman, I am President-Elect of the American Organization of Nurse Executives, which represents 4,000 nurse executives from house institutions across the United States. On behalf of our membership, I thank you for this opportunity; and I will summarize my statement.

While my remarks are not specifically related to the Veterans' Administration hospitals, they do reflect the status of hospitals and nursing in the same communities in which VA hospitals exist. In today's health-care environment, hospitals have strong incentives to provide no more inpatient care than is absolutely necessary and appropriate.

As a result of shortened lengths of stays, today's average hospital patient is much more severely ill than in the past. Because of this, coupled with the increases in technology, patients require more nursing care. Increased severity of illness and subsequent rise in required nursing care is reflected by the change in ratio of nurses to patients in our hospitals. That ratio increased 70 percent between 1975 and 1985. In addition, the demand for nurses has increased in growing outpatient services, home care, and special services to our elderly.

Coinciding with this need for RNs, there have been several studies which have shown a nurse's unique value in our hospitals. One of those, done in my own institution, George Washington University, studied the most significant factors related to outcomes of patient care in intensive care units—13 of them across the country—and it showed that the most significant factor with the quality of interaction and communication between medical staff and nursing staff.

It is my own opinion that this type of quality of interaction is greatly enhanced when the nursing staff participates in decision-making from the top to the bottom of the institution. Despite the increased number of nurses in the work force, the increasing demand for RNs has far surpassed the available supply, creating one of the worst nursing shortages in the history of this country.

A 1986 AONE survey found that the overall RN vacancy rate in hospitals was 13.6 percent. This is twice the vacancy rate in 1985. While virtually all types of hospitals seem to be experiencing a shortage, it appears to be worse in certain regions of the country and in certain specialties. The mid-Atlantic, Pacific, and east-north-central regions of the country reported the greatest number of vacancies, but the trend seems to be spreading from both coasts inward.

More than 90 percent of all hospitals that reported RN vacancies were recruiting medical-surgical nurses and 80 percent reported difficulties in recruiting into intensive care and coronary care units. This study will be repeated within the next 2 months.

Declining enrollment into nursing education programs means that the current shortage could become potentially worse. Between 1983 and 1986, enrollments into baccalaureate nursing education programs declined by 19 percent and into associate degree programs by 29 percent. AONE believes that the nursing shortage is a problem germaine to the American public's well-being, and therefore it is the responsibility of society to address this issue with the nursing profession.

Our organization has made nursing recruitment into the profession as well as into hospitals a priority and is currently undertaking a national review of existing recruitment and retention strategies and their effectiveness. We hope to distribute this information in the near future.

In addition, AONE strongly supports the following strategies: increasing funding for nursing education, enhancing the position of nurses in the workplace, ensuring fair and adequate compensation packages for nurses, and enhancing the image of nursing as a profession and the funding of special projects to demonstrate effective recruitment and retention strategies.

Mr. Chairman, the actions to assist the Veterans' Administration with their resolution of the nursing shortage contains several of these strategies. They will be followed closely by nurses working in all sectors as possible components of any comprehensive solution to the country's nursing shortage in the long run.

Thank you, and I will be happy to answer any questions.

Senator DeConcini. Thank you very much. Those are some very good statements. I do have some questions.

[The prepared statement of Dr. McCarthy appears on p. 298.]

Senator DeConcini. One question I would like to pursue with each of you, if you could respond, is on the idea of a bonus program. This has been quite successful in the private sector, and I have observed it personally in some business observance and involvement. But I would like your response in regard to a question for a bonus program for VA nurses.

If the VA paid a $20,000 bonus to, say, 10 percent of its nurses, that would cost $66 million. Would you agree that a bonus program would have to be paid to all nurses, or available to all nurses, at least, at a particular facility with a recruitment problem or otherwise? Or would we end up with major moral problems? How do you view such a bonus program?

Ms. Lloyd. I would be pleased to answer that question.

I do believe that we would want to address a bonus not only for recruitment but also for retention because I think the problems that we are having in retention and recruitment are because we have trouble attracting the nurses, because we are not competitive. Then when we get them in the system and the conditions while they are there are not as favorable as in the private sector they leave, and we have a revolving door.

So, I think we have to address both recruitment and retention, and I think we could do that with a bonus.

Senator DECONCINI. Dr. Naylor?

Dr. NAYLOR. The private sector has used bonuses in the past to deal with other periods of nursing shortage. This strategy has, however, resulted in significant problems. It has been effective in recruiting individuals into hospitals. There has been a lot of job-hopping associated with it. What has not happened, especially within the hospital system, is any attention paid to economic restructuring to avoid compression of salaries. For example, as you introduce these bonus systems, you increase the starting salary for beginning professionals enrolled in hospitals.

What has not occurred along with this is a major change in the advancement of experienced nurses. In 1985, the national average starting salary was $20,340; for nurses with 10 years of experience in 1985, this salary was $27,000. This leads to major issues of job dissatisfaction for the experienced nurses; and those are the ones, I think, that we really need to be concerned about as we introduce new recruitment and retention systems.

Senator DECONCINI. Dr. McCarthy?

Dr. MCCARTHY. My comments would be the same as Dr. Naylor's. I think that a bonus for all nurses working in a particular region where it was hard to recruit would affect everyone, and I think that could be successful.

Senator DECONCINI. Yes. You would have to do it in the whole region, obviously, or I think you would; or you would have a great big mobility of nurses going to where the bonuses were, would you not?

Ms. LLOYD. I would think so.

Senator DECONCINI. I appreciate your testimony. It has been very helpful. Thank you.

We will now have the next panel of Mr. John Mulholland, Director of Field Services, American Federation of Government Employees; Ms. Tricia Thomas, Legislative Director, accompanied by Elayne Tempel, Labor Relations Specialist, National Federation of Federal Employees; Dr. Howard Green, Member of the Executive Board, National Association of VA Chiefs of Staff, and Chief of Staff of the VA Medical Center at White River Junction, Vermont; Dr. Gloria Hope, Executive Director of Washington Governmental Affairs Office, American Nurses Association; and Dr. Peter Hawley, President, National Association of VA Physicians.

Mr. Mulholland, will you lead off? Due to time constraints and another panel to be heard, we would ask that you summarize your statements; and the full statement will appear in the record.

STATEMENT OF JOHN MULHOLLAND, DIRECTOR, FIELD SERVICES, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. MULHOLLAND. I will be happy to do that, sir. I am John Mulholland, the Director of Field Services for AFGE, a division of the American Federation of Government Employees. We represent 700,000 Federal workers.

Senator DECONCINI. How many?

Mr. MULHOLLAND. 700,000, of which some 17,000 are professional employees in the Veterans' Administration. We welcome the opportunity to comment on these bills. Because we are going to support them all except one, I will move on and discuss that. That deals with those dealing with disciplinary boards. That is S. 1136 relating to the role of disciplinary boards in disciplinary actions for title 38 employees. Title 38 employees include most professional employees in the VA such as doctors and nurses.

The bill essentially does two things. It limits the scope of disciplinary boards to more serious offenses involving separations, lengthy separations, et cetera. It would leave minor offenses to internal grievance procedures established by regulations. We applaud the review of disciplinary procedures of title 38, that current practices are unfair and are perceived as unfair by employees. The current system does not bring justice to the workplace.

However, we cannot support S. 1136 as drafted. The current problems are aggravated by an unforeseen and unintended consequence of Congress' efforts to address the pay problems of these employees. In 1983, Congress removed some VA employees from pay provisions of title 5 so that recruitment and retention problems could be more adequately addressed.

However, the language was so broad that it has been misinterpreted by the Veterans' Administration to exclude these employees from labor-management provisions of title 5.

The end result of congressional efforts to address the pay problems of these employees has been to deny these employees the protections granted to all other professional employees in the Federal Government. Congressional support for the Civil Service Reform Act was predicated on the theory that all Federal employees would have access to a negotiating grievance procedure. The exception to this was the CIA, FBI, DEA, and other like agencies.

Clearly, VA employees should not be included in this excepted group. The latest figures from OPM indicate that there are 135,263 professional employees in bargaining units in the Federal Government. Outside of the VA, all of these employees are covered by negotiated grievance procedures for review of disciplinary actions. Included are doctors and nurses at military hospitals and the Public Health Service, lawyers, engineers, chemists, scientists, and the list goes on.

There is not a shred of evidence that an impartial review of disciplinary actions has any detrimental effect on the operations of the DOD or any other agency which employs professionals. Moreover, the Veterans' Administration's 101 nonprofessional employees, including nurse's assistants, dieticians, as well as some professional employees such as psychologists, scientists, vocational rehabilitation counselors are covered by a negotiated grievance procedure.

Thus, we have the untenable situation where one group of bargaining employees is working side-by-side with another group of bargaining employees, with disparate treatment with regard to review of disciplinary actions. Not only is this unfair and demoralizing to employees, but it is just poor personnel management.

We urge the committee to include language which would return title 38 employees to parity with all other professional employees by entitling them to a negotiated grievance procedure which would include binding arbitration. We have attached language that would do this and, as a minimum, those disciplinary actions not subject to disciplinary boards should be covered by the negotiated grievance procedure instead of by agency grievance procedures.

S. 1055 would bring other employees into title 38, and we would not oppose that, as long as they continued to have the rights that the Civil Service Reform Act was intended to bring them. We have negotiated contracts dealing with this issue of pay for on-duty time. It is voluntary now under the contracts. We don't think Congress by legislation should set aside contract provisions that have been freely entered into between the VA and AFGE.

On the whole, we applaud this opportunity to look at legislation that would bring quality health care to the veterans, improve recruitment and retention, and fix pay as it should be. I would request that the rest of my statement be included in the record, and that would conclude my statement.

Senator DECONCINI. Thank you very much. Ms. Thomas, would you please proceed?

[The prepared statement of Mr. Mulholland appears on p. 306.]

STATEMENT OF TRICIA THOMAS, LEGISLATIVE DIRECTOR, NATIONAL FEDERATION OF FEDERAL EMPLOYEES, ACCOMPANIED BY ELAYNE TEMPEL, LABOR RELATIONS SPECIALIST

Ms. THOMAS. Good morning, Mr. Chairman. My name is Tricia Thomas, and I am the Legislative Director of the National Federation of Federal Employees. With me today is Elayne Tempel, Labor Relations Specialist, who works with the VA Council of NFFE Locals. We represent employees of every occupation, both professional and nonprofessional, within the VA hospital system. Our members include registered nurses, licensed practical nurses, doctors, dentists, pharmacists, engineers, and even police officers and firefighters, to name just a few of the positions. For the most part, these employees have served the Veterans' Administration for many years, devoting their careers to the care of this Nation's veterans. With their experience and expertise, the VA's medical care personnel are without a doubt the most valuable resource the VA hospitals have.

We appreciate the opportunity to appear before the committee today to testify on the recruitment and retention of health-care personnel within the VA and to discuss several bills related to the VA's personnel system. During the past few years, we have witnessed a growing problem with the recruitment and retention of these personnel, particularly within the field of direct patient care. And unfortunately, this comes at a time of increasing demands on the VA hospital system. As the Nation's veteran population ages, they require greater care which means the allocation of more resources to each patient. This includes both technology and direct patient care. As the committee well knows, the Veterans' Administration has been unable to recruit or retain the necessary staff.

There are several bills before the committee today which indicate your intent to rectify some of the problems which have long plagued the VA medical system. We commend the committee for your efforts on behalf of the veterans served by the Administration and by the employees who serve them.

While we have concerns about some of these legislative proposals, we commend your efforts to ensure the highest quality of medical care to this country's veterans. We represent medical personnel in VA hospitals throughout the Nation, and we are aware of staffing problems of varying degrees in each of these facilities.

Whether the hard-to-fill occupation is a registered nurse, pharmacist, or critical care nurse, there is one factor common to all: the VA's compensation and personnel policies have not given the agency the resources to remain competitive in its hiring practices. Last year, the VA undertook a study of its health occupational staff, which confirmed the agency's recruitment problem—a problem which we have been acutely aware of in the hospitals we represent. I would like to use the VA Medical Center in East Orange, New Jersey, as an example of the extent of the staffing problems.

The East Orange Center must compete for personnel with numerous hospitals in the area. We looked at several recent editions of the East Orange Star-Ledger Newspaper to find out how competitive the VA Center is. What we found was a host of advertisements for private sector hospital jobs, which offered more flexible work shifts, paid tuition, and better salaries than those offered in the East Orange Medical Center.

While the VA Center offered entry level nurses between $20,378 and $23,207, the same level nurses could earn from $1,500 to $5,000 more at other community hospitals. It is hardly surprising then that the VA hospital last year experienced an 18 percent turnover of registered nurses and a 35 percent turnover of LPNs. High turnover rates translate into greater workloads for the already overburdened employees.

For nurses who are already physically and mentally overburdened, the prospect of employment at other hospitals becomes increasingly more attractive. We have also heard from our members that the lack of appropriate, modern technology further burdens employees. An outdated recordkeeping system, for example, requires valuable time an RN could better employ in direct patient care.

Two bills under the committee's consideration today seek such a solution to the Veterans' Administration's high attrition rate. S. 713 would give the Administrator the authority to offer a recruitment and retention bonus to registered nurses in exchange for obligated service.

While the idea of offering bonuses to new employees could help address the recruitment problem, it could just as easily create a new one if the bonus is not available to current hires. The VA's most valuable resource is not the RN or LPN who is not yet employed. It is, instead, the experienced worker who is already employed by the agency. It is not clear to me that the bonus authorized under S. 713 would be available to employees currently on the VA payroll. To preclude these medical personnel from such a bonus will only cause resentment and escalate turnover. We would suggest then that any bonus be extended to all registered nurses.

We believe that higher levels of pay are the solution to the VA's attrition and recruitment problems. Upgrading the positions of medical personnel is the most viable long-term solution. However, in the absence of this option, a recruitment/retention bonus for both new and current employees could help stem the high attrition rate.

The Veterans' Health-Care Act of 1987 offers another approach to attracting and retaining qualified health-care personnel, and I would like to comment briefly on this legislation. The bill's sponsors have recognized that the Veterans' Administration must become more innovative in its hiring and personnel practices. We fully support the proposals to give nurses who work on Saturday the same premium pay available for Sunday work. Likewise, we are in favor of opening up the policymaking and fiscal committees at VA Medical Centers.

Senator DECONCINI. Ms. Thomas, I am sorry, but we are running out of time. If you could summarize, please?

Ms. THOMAS. In summary, Mr. Chairman, we would like to support your efforts, as we have indicated, to help the VA in its efforts to recruit and retain personnel.

Senator DECONCINI. Thank you. Your full statement will appear in the record. I am sorry I had to do that to you. Dr. Green?

[The prepared statement of Ms. Thomas appears on p. 326.]

STATEMENT OF DR. HOWARD H. GREEN, CHIEF OF STAFF, WHITE RIVER JUNCTION VA MEDICAL AND REGIONAL OFFICE CENTER, AND MEMBER, EXECUTIVE COMMITTEE, NATIONAL ASSOCIATION OF VA CHIEFS OF STAFF

Dr. GREEN. Thank you. I would like to thank the committee on behalf of the National Association of VA Chiefs of Staff, whom I am representing today. I would like to make a technical correction to my testimony. In my written testimony I mentioned Booze-Allen-Hamilton as the consultant on S. 631; it is Coopers-Lybrand. I wouldn't want to deny them the credit for $871,000 worth of work. [Laughter.]

Senator DECONCINI. The record will so show.

Dr. GREEN. I am going to make my testimony really quite brief, Senator DeConcini. I think the nursing panel said a great deal, and you ought to listen very carefully to what they have to say. I would like to make a few brief comments.

Our competition is a local issue. Salary parity in the local negotiations becomes the real issue, and we must be able to get to that salary parity expeditiously. The previous special rate process was so slow and flawed that it had no significant effect. That has been worked on, and I think there is a solution in sight to that. The market is so bad that local negotiations frequently determine the price.

In certain locations, cars are being offered. The local administrator has the capability, with a bag of money, to add $1,000 or so in order to get the critical personnel they need. I am not saying we can ever get that in Federal Government, but I want to tell you that in some of the really bad areas for recruiting, there is considerable local flexibility.

Even though our statement reflected the fact that we did not favor bonus legislation as the means of approaching the nurse shortage because we think it is crucial. In the last 3 to 4 days I have talked with many of my colleagues so that I could indeed represent this as testimony representing them. Some of them are so desperate that they need anything they can get to recruit and retain nurses. Even though the association feels that the bonus approach isn't the best way to go necessarily, we recognize that local bonuses could be a value in certain restricted circumstances.

In general, the benefits that I have outlined in my testimony are the ones we feel are important. I would like to add the fact that one of the nurses concerns is their involvement in nonnursing duties—taking specimens to the lab et cetera—and we think we have to make a major effort in supporting them with ward clerks and other people to take away the nonnursing duties.

We feel the tuition reimbursement must be indeed universal and not discriminatory because the central purpose is to recruit and retain nurses. I think we have to take the chance that, after tuition is used that somebody may bail out after a period of time. Private industry does take this risk also.

Nursing staff, in my view—and I think in the view of most of my colleagues—is really not adequate. We do not have enough nurse ceiling in the Veterans' Administration. Part of that is due to an overall budgetary problem; the other has to do with a subtle but definite rediversion of resources within medical centers mandated by programs that have not been funded with personnel. I would mention to you quality assurance, ADP, A76 initiatives, means testing, increased reporting requirements, and activations of new facilities which come off the top without additional ceiling.

Two other comments before I finish. One has to do with the standardization of medical supply issues. As written, the bill is too restrictive. I gave an example in my testimony that I will not repeat about the danger of too much standardization. Our house staff works in an environment of affiliated medical centers, and we have done everything we can in our local medical center to standardize supplies with our affiliate, for the reason that mistakes are made if critical care personnel are not familiar with the supplies, particularly in dwelling catheters, IV solutions, and things like this.

And the last comment that I have has to do with the problem of AIDS. The problem of AIDS is a moving target. One has to be able to react in very short times to the increasing requirements. I do not feel that the previous RAM model, not only in its execution, but in its conceptual framework, was adequate. As a matter of fact, it was seriously flawed.

I don't think you can ever build a model that will react well to the ongoing needs. I think models are for keying on important factors, but to allocate money based on mean costs, hardened into a model that is not perfect, is folly.

I want to thank you for the opportunity to testify, sir. Our association certainly thanks you, and I will be glad to answer questions.

Senator DeConcini. Thank you, Dr. Green. Dr. Hope?

[The prepared statement of Dr. Green appears on p. 338.]

STATEMENT OF DR. GLORIA S. HOPE, DIRECTOR, DIVISION OF GOVERNMENTAL AFFAIRS, AMERICAN NURSES ASSOCIATION

Dr. Hope. Thank you, Mr. Chairman. As a retired VA nurse, the last 10 years of which I served as Deputy Director of the VA Nursing Service, I am pleased to present the testimony of our 188,000 ANA members. A significant number of them are VA nurses. ANA has also represented VA nurses in collective bargaining units since 1967 through its 53 constituent State nursing associations.

Approximately 97 percent of all nurses are women, and their work has been undervalued. The result is salary compression. Given the skill, effort, responsibility, and working conditions of nurses, such compensation is neither attractive enough to lure new recruits nor competitive enough to retain nurses with years of experience.

Today, almost 80 percent of all nurses are employed; yet student enrollment is declining. Increased patient acuity and earlier discharges create workload problems and contribute to low morale and further dissatisfaction. Shortages of 65 to 80 nurses in VA hospitals in some areas results in critical care units with increased patient-nurse ratios, in coronary intensive care units that are staffed with outside agency nurses who make $18 to $24 an hour, which is more than what a VA nurse makes. We are concerned also that operating room nurses and continuing education staff are placed on medical surgical units and in stepdown areas to cover for inadequate staffing. Morale is obviously lowered also when nurses cannot attend in-house training programs because they cannot leave their unit due to minimal staffing.

Some nurses report that attendance at outside professional education advancement programs does not occur even when the individual is willing to bear the cost and administrative or annual leave is not granted because of staffing concerns.

In the past, the VA attracted nurses by stressing the professional education and research opportunities within the system; and obviously, nurses will go elsewhere to pursue their professional interests and needs if these cannot be met in the VA. Can you imagine a recovery room nurse who is past due on her annual CPR certification because she has had to cancel attendance at several training sessions because she cannot leave the unit? How can the VA assure up-to-date professional standards of care when such occurrences are happening at facilities with increasing regularity?

We do not believe that the bonus offered in S. 713 is a viable option for retention of tenured VA nurses. The bonuses are short-term solutions. They attract people initially, but if inadequate staffing persists and dissatisfaction occurs, they will leave. ANA supports the VA hospital scholarship program and urges its continuation and continued funding.

Special pay authority has really not been successful in recruting the numbers of nurses needed for certain VA facilities due to inadequate funding and cumbersome, time-consuming procedures. We believe that if junior grade nurses at 92 VA hospitals receive special pay that places them at the top of the scale, perhaps a better strategy would be to delete junior grade or restructure the present salary levels. Entry positions could be restructured to accommodate a new salary for nurses.

ANA is pleased that S. 1195 proposes several options that nursing has long advocated. The educational system payback should not be viewed as so burdensome that it inhibits enrollment in the program.

Although we recognize the budget concerns which necessitate priority for senior applicants in the scholarship program, other disciplines and agencies are not so restricted. The bill for the first time will authorize a tuition reimbursement; yet we are disappointed that it is a clone of the existing scholarship program. Seventy-seven of the VA facilities believe tuition assistance would be a major advantage in recruitment and retention.

ANA has major concerns regarding the selection of applicants for the tuition reimbursement program. The bill sets the program ostensibly as a merit reward or bonus; we suggest that the VA make a reasonable cost estimate for the program and request sufficient funds to realistically compete with the private sector. We urge the committee to reconsider the program and designate it as an entitlement, perhaps utilizing the funds that would have been used for bonuses.

ANA endorses provisions for Saturday pay. In a hospital of the VA size and status, it is out of line with the private sector if they do otherwise. Special pay is especially important when nurses only receive one weekend out of every three. The VA is at a disadvantage when the private sector provides every other weekend for full-time nurses.

During the week, VA nurses are overworked because of inadequate staffing and increased workloads, and then comes the weekend, which increases the nurse's responsibility because of decreased staffing in the other hospital departments and changes in staffing schedules. I would submit to you that it is not their patient care services, but nonnursing duties that have impacted nurses decisions to stay. VA hospitals must have appropriated authority and dollars to employ adequate support services.

The VA must consider what other revisions would lessen administrative time burdens and preserve employee due process in the disciplinary actions as set forth in the bill.

In closing, ANA reiterates its commitment to assure quality nursing care to our Nation's veterans. As a profession, nursing has always responded to a health-care crisis; and we pledge to cooperate with the VA to provide the nurses necessary to operate the VA health system. We hope that these hearings culminate in a committed collaborative effort to maintain the ability of the VA to provide quality health care.

I thank you again for the opportunity to present ANA's concerns.

Senator DeConcini. Thank you, Dr. Hope. Dr. Hawley?

[The prepared statement of Dr. Hope appears on p. 343.]

STATEMENT OF DR. PETER HAWLEY, PRESIDENT, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. Hawley. Thank you, Mr. Chairman. My name is Peter Hawley. I am a physician, my specialty being clinical pathology; and I am also a veteran. I appear here today in a strictly unofficial capacity in respect to the Veterans' Administration, but as the President of the National Association of VA Physicians. I speak on behalf of the veterans' medical program and all those health-care professionals who serve therein.

In the almost 9 years I have served at the VA, I have seen a continual erosion in our ability to attract talented, industrious men and women to fill jobs serving our veteran patients. Benchlevel laboratory technologists who are title 5 employees have left to go into private hospitals across the street to earn more money than their VA supervisors.

It is no longer uncommon to have technologists positions vacant for months or even longer than 1 year. The situation becomes an outright disaster in respect to title 38 employees.

The shortage of nurses is so acute that we are actually closing down whole wards and curtailing many essential functions. Mr. Chairman, NAVAP welcomes and encourages any attempt to promote the hiring and long-term retention of skilled professional personnel by using scholarship programs, pay for on-call services, and bonus pay for extended service commitments. Hopefully, these will help build a cadre of highly committed, professional personnel to serve our veteran patients. Any attempt to codify and expand the rights of title 38 employees for grievance to adverse actions are most welcome. There are few recourses open to this class of VA employees when compared to their title 5 counterparts, especially those in part-time status.

NAVAP would fully support review by disciplinary boards of all adverse actions which would curtail the clinical privileges of physicians. The agency would have us believe that only changes resulting in demotions with loss of pay, long suspensions, or removals should be subject to review by disciplinary boards; but let me assure you that the loss of the ability to fully practice one's specialty is a far greater penalty than a suspension for a few weeks. Skills that take years to develop must be continually nurtured to remain sharp.

We would also question the wisdom of delegating the authority to appoint the disciplinary board back to the local level. The agency already functions as prosecutor, judge, and jury. If this authority is delegated back to those who may have leveled the charge in the first place, then we can add accuser to the list. One can hardly claim that due process is served under these circumstances, but rather that this becomes a mockery of the review system.

Until all review or appeals of discplinary actions are removed from the precincts of the agency and are put in the hands of a truly impartial body, we must conclude that the VA physician remains subject to capricious and vindictive actions by the Administration.

Also, we do not look with favor upon the creation of yet another board to review VA physicians who have successfully completed their probationary periods. We already have too many boards.

If we are truly interested in first quality health care for our veterans, I suggest the following actions be taken. Discriminatory grandfathering differences between title 38 and title 5 annuity calculations must be eliminated. The continuing $2,682 reduction in VA physicians' special pay should be stopped. The agency should be required to document the last decade's changing number of administrative personnel as compared to those of us who actually take care of patients.

Monetary and other creative inducements must be increased well beyond current levels. You only get what you pay for.

The agency's handling of disciplinary actions must be examined and revised to truly protect employees from capricious and vindictive actions.

I wish to thank you for your invitation to hear the concerns of VA physicians in their attempts to deliver first class quality care to our veteran patients. I will be happy to answer any questions.

[The prepared statement of Dr. Hawley appears on p. 356.]

Senator DECONCINI. Ladies and gentlemen, thank you very much. We do have some questions, but due to the votes that we have had this morning and the schedule, I am going to ask if you would be kind enough to respond to them in writing for the committee. So, we will forego any more dialog. I want to thank you for your fine testimony; it is very helpful.

We will go to the next panel. Thank you. We will have Mr. Jack Dack, Legislative Committee, National Association of State Veterans' Homes and Commandant, Iowa Veterans Home; and Mr. Carl Tuvin, Legislative Liaison.

Mr. Dack, I am going to ask that you summarize your statement; and Mr. Tuvin, if you have something to add, I am going to ask you to make the statement here. I am going to have to step out for a minute, but I am only going to be gone about 30 to 60 seconds, so please continue. I will be right back.

STATEMENT OF JACK J. DACK, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE VETERANS' HOMES, AND COMMANDANT, IOWA VETERANS HOME, ACCOMPANIED BY CARL TUVIN, LEGISLATIVE LIAISON

Mr. DACK. Mr. Chairman and members of the committee, it is a privilege for me to appear here today and present the views of the National Association of State Veterans' Homes pertinent to S. 6, S. 216, and S. 1089. Such legislation contains issues of importance to our members: No. 1, proposed per diem increases for health-care services provided veterans in State homes, and No. 2, to improve the State Veterans' Home Grant Program.

I am Jack J. Dack, Chairman of the Legislative Committee and with me today are Fred Traill, Commandant, Michigan Veterans Facility, Grand Rapids; Dr. Melvin Friedman, Chief Executive Officer, New Jersey Home for Disabled Veterans; members of the Legislative Committee, Carl Tuvin, Washington Representative; and in the audience, Robert Buckner, Administrator of the Mexico, Missouri Veterans Home. We have submitted our written testimony and request that it and our oral testimony be made a part of the permanent record of this hearing.

Mr. STEINBERG. It will be.

Mr. DACK. First, Mr. Chairman, I want to express the sincere appreciation of the association to you and to members of the committee and committee staff for your continuing efforts to improve this most important program that directly affects both the health care of veterans and veterans' homes.

As noted in the association's written testimony, the State homes provided 4,679,406 days of care for the veteran population of the United States during fiscal year 1986. The per diem payment paid through the Veterans' Administration for these days of care averaged $13.54 across the three levels of care provided. A total of 2,922,695, or 62.5 percent, of these days of care were nursing home care. The per diem increases as proposed by S. 6 and S. 216 are extremely welcome to the association and are viewed as a positive sign that Congress wants to keep the Federal share of the cost of supporting veterans in State homes in some sort of equitable relationship.

Your action is particularly welcome in the context of development at the State level, three of which I will cite for information. One, in Oklahoma, the Governor announced his intent to eliminate the State home program, citing economic difficulties as the reason. When the Oklahoma Legislature indicated it would not accept this approach, the Governor's fall back position still under consideration is that of a 30 percent across-the-board cut in the State-owned program funding.

In Michigan, the construction grant application for a third facility is in the process of being withdrawn as a part of a continuing effort to reduce the size of State government.

Three, in Iowa, 60 skilled beds have been closed to meet budgetary reductions of a year ago. The National Association would again encourage and request that the per diem rates paid to State homes for all three levels of care be put on some method of annual review as a part of this legislation.

We once again would propose a method in which such rates can be anchored to the Veterans' Administration costs with a built-in cap. Past and current methods of reviewing the Federal participation in the State home program result in annual increases in the cost to the States of operating these homes since these homes are no less subject to the inflationary pressures than are other programs operated directly by the Veterans' Administration or those services for which the Veterans' Administration contracts.

The continuing resistance of the Veterans' Administration to support equitable per diem payments in State homes fuels the arguments of those State governments and legislators who more and more openly question why the States are in the business of caring for veterans in the first place.

The association commends the Congress on its efforts to increase funding of the Construction Grant Program and to facilitate the entrance of new States into this shared service program for veterans. However, we must reiterate that operational funding by the Federal Government on an equitable basis is absolutely crucial to efforts to attract new States into the State home program to retaining those States already providing services to the Nation's veterans and, of equal importance, to absorb the 10 percent shift in provider mix from the Veterans' Administration to the State home program.

The National Association of State Veterans' Homes supports S. 1089 to improve the State Veterans' Home Grant Program. It appears to provide flexibility in scheduling for States in selecting of contractor and awarding of contract. States would have more time to do a quality job of design. It will also provide authority for awarding grants during the transitional period, July 1 to October 1, 1987.

Mr. Chairman, this concludes our remarks. We thank you for allowing us to testify and to work with you and your professional staff on this important endeavor. We would be pleased to respond to questions from the committee, if you so desire.

[The prepared statement of Mr. Dack appears on p. 361.]

Senator DeConcini. Thank you. Mr. Tuvin, do you have anything you want to add?

Mr. Tuvin. The only thing, Senator, I would like to add is just a word of thanks to the minority staff and the majority staff for working with us in our per diem increase and other problems that this association has had while I have been with them over the past 2 years.

They have been patient listeners, and we have shared a good working relationship with them in solving some of our problems. The per diem problem is top notch on our list this year, and we hope that we can achieve our goal. It is a little less than what the association wanted in some of our meetings contained in your bill, but we certainly appreciate the efforts.

And we hope that we can get a possible annual review of this situation. Thank you.

Senator DeConcini. Thank you very much. Before you leave—I don't have any questions—but I note that Senator Cranston's statement—his opening statement this morning—and I presume you have had a chance to hear it or have a copy; and he discussed the two measures before the committee which would provide for an increase in per diem payments to State veterans' homes. In Arizona, I am sorry to say we don't have one, but some day we will grow up and play with the big boys, too; and our legislature will create such a home.

But in regard to that, Senator Cranston said, and I would like to quote:

> We have been working closely with the State Veterans' Homes organization to try to find a formula that would provide stability to the reimbursement program and also be basically prudent. In view of the increased reliance which the VA has decided to place on the State home program to meet the needs of the dramatically growing number of older veterans, I am giving very serious consideration to recommending such a formula during our committee markup of this legislation.

That was in his statement, and I want to associate myself with those comments. And I pledge my support.

I thank your organization and your members for providing the political importance and support for periodic increases in the per diem. It seems to me it is long overdue. I think you have played a major role in bringing that to our attention, and I hope we can do something with that.

Mr. DACK. Thank you. We appreciate those efforts.

Senator DECONCINI. Thank you very much, gentlemen.

Our last panel will be Mr. Philip Riggin, Director of the National Legislative Commission, The American Legion; and Mr. Robert Lyngh, Director of the National Veterans' Affairs and Rehabilitation Commission; Mr. David Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans; Mr. James Magill, Director of National Legislative Service, Veterans of Foreign Wars. Instead of Mr. Magill, we have Mr. Dennis Cullinan; and Mr. Frank DeGeorge, Legislative Director, Paralyzed Veterans of America.

Gentlemen, I am going to ask you to summarize your statements, and I am also going to advise you that I am going to have to leave shortly; but I want you to finish your statements. We will start with Mr. Riggin.

STATEMENT OF E. PHILIP RIGGIN, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION COMMISSION

Mr. RIGGIN. Thank you, Mr. Chairman. Mr. Lyngh, as you indicated, is with me this morning. He is prepared to present the summary of The American Legion's statement, and we will both be available to respond if you change your mind to any questions that the committee may have.

Senator DECONCINI. All right, very good.

Mr. LYNGH. Mr. Chairman, we submit our entire statement for the record and will offer brief remarks in extension of the support expressed for the measures under consideration.

The American Legion strongly supports section 7 of S. 6 that would increase the per diem rates provided by VA to State homes for domiciliary, hostel, and nursing home care. S. 216 deals with the same subject matter. If the Federal Government is to be able to look to the States to share the burden of caring for the Nation's aging veteran population, it is essential that the per diem allowances by VA be adjusted at regular intervals to reasonably reflect the cost of care provided.

To place this matter in a negative context, it is our opinion that, to the extent the Federal Government does not make such adjustments, there may well be an increasing reluctance by some States to expand and maintain facilities to care for these veterans. The gain to the Federal Government in assisting the States is obvious and will certainly, as a cost-effective method, meet the needs of older veterans, especially those who have come into their later years without the personal resources to decently care for themselves.

With reference to section 9 of S. 6, we wish to emphasize that The American Legion is keenly aware that there are those in Los

Angeles County who are trying with great intensity to acquire land from the existing campus of VAMC, West Los Angeles. The University of California at Los Angeles is one such, and there are developers who clearly have ambitious plans for utilization of this land. These individuals and entities have no right to this land and should not be allowed to have it.

The present campus at West Los Angeles was specifically given by the original grantors for the care of veterans. VA has both a legal and a moral responsibility to fulfill that trust in perpetuity.

With reference to the title section of S. 6, we would say that the VA has indeed done many things in recent years to develop plans and programs to care for the aging veteran population. For what has been done, all with encouragement and support of the Congress, VA is to be commended. We believe it is now time to draw all present programs and the planning and research that have been under way into a plan that can be perceived and dealt with comprehensively. In addition to helping veterans, such a plan will be of inestimable value to the entire field of geriatrics and gerentology.

S. 894 and S. 939 are intended to correct what is an obvious inequity in existing law which prohibits provision of medical care for the service-connected disability of veterans of the U.S. Armed Forces who are not American citizens and are living outside the United States. Including those who served during the Vietnam war, there is a considerable number of these individuals. Simple justice mandates this nation, which accepted and used the services of these noncitizens in furtherance of its national interest, to provide the care to which they clearly should be entitled.

In conclusion, Mr. Chairman, The American Legion commends the committee in considering the range of bills here under consideration for addressing a substantial number of matters affecting the VA health-care program. Taken as a whole, they will strengthen the agency's ability to care for the maximum number of veterans who are eligible for and entitled to care by the Federal Government. Thank you, sir.

Senator DeConcini. Thank you very much. That is a good statement; and Mr. Riggin, I expect you want to just stand pat with that statement?

Mr. Riggin. Yes, sir, I do.

Senator DeConcini. Very good. Thank you.

Mr. Lyngh. Thank you.

Senator DeConcini. Mr. Gorman?

[The prepared statement of Mr. Riggin and Mr. Lyngh appears on p. 378.]

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. Gorman. Thank you very much, Mr. Chairman. I would like to say how very much the DAV does appreciate this opportunity to relate our views on the various legislative items that are included on this rather full hearing agenda this morning. Mr. Chairman, our written testimony reflects our views and positions on all of the measures before the committee; and therefore, I would like to take a few minutes to discuss those areas of particular concern and interest to the DAV.

With reference to S. 6 and section 2, so long as clarifying report language is related as suggested in our written testimony, then certainly we have no objection to enactment of that provision. The DAV supports section 3 proposing to clarify the eligibility for receiving domiciliary care. We support that portion of section 4(a) explaining eligibility for receiving readjustment counseling services for those veterans serving on active duty after May 7, 1975 and who were subjected to hostile or armed conflict.

We support section 4(b) proposing a delay for the transition period concerning the Vet Center Program. Mr. Chairman, we also support section 5 of the bill, which would mandate the Administrator to conduct a pilot program to furnish eligible veterans medical, rehabilitative, and health-related services in noninstitutionalized settings, thus obviating or dramatically reducing the need to furnish the veteran with hospital or nursing home care. Also, we greatly appreciate the bill language which would accord priority for such services to be extended to service-connected and other veterans who are determined to be most in need of those services.

We support section 6 dealing with the Administrator's authority to issue rules and regulations relating to the provision of health-care services to veterans. Section 7 has the full support of the DAV as does S. 216, which contains identical provisions regarding increasing per diem rates payable to State veterans 'homes.

Mr. Chairman, we are generally supportive of section 8; however, we do object to that portion of the proposed amendment that would remove the statutory requirement that one Assistant Chief Medical Director for geriatrics must be a physician who is either trained in or possesses extensive experience in the field of geriatric medicine. It is our view that, when considering the range of issues and all the other medical considerations and disciplines involved, in attempting to meet the unique needs of a rapidly aging veteran population, that a physician with suitable qualifications is the only possible and logical choice to address this pressing issue.

Along those same lines, Mr. Chairman, we support section 10 of S. 6. Finally, with reference to S. 6, we support section 9 prohibiting the accessing of certain lands at VA Medical Centers in West Los Angeles and Sepulvada, California.

We support S. 631, proposing to improve the VA's procurement program. Mr. Chairman, the DAV is pleased to support S. 894 as has been introduced by the ranking minority member, Senator Murkowski. If enacted, this measure would recommend section 624 of title 38 to remove the rather restrictive requirement that a U.S. veteran must also be a citizen of this country in order to receive VA health-care services.

Although not explicitly stated in bill language, this change would greatly benefit those individuals who are now Canadian citizens, but who are also veterans of the U.S. Armed Forces and who have incurred service-connected disabilities as the result of such service.

Current law renders it rather difficult for these veterans to receive VA-sponsored medical care to which they are entitled as a result of their honorable military service, and we feel this measure would substantially reduce those difficulties.

Finally, Mr. Chairman, I would like to lend the full support of the DAV to both S. 713, as introduced by Senator Murkowski, and S. 1195, which Senator Cranston has so timely introduced. Taken in combination, these two measures would in our view greatly assist the VA in overcoming some serious difficulties now being experienced by the agency in the recruitment and retention of qualified health-care personnel for employment in the Department of Medicine and Surgery.

S. 713 would authorize the Administrator to pay a bonus to registered nurses accepting employment with the agency when certain stipulations are mutually agreed upon. The major provisions of S. 1195 would provide for the agency's needed flexibility for appointment and pay purposes concerning pharmacists and occupational therapists, expand the health professional scholarship program to physical therapists and other key health-care providers, as well as lengthen the period of obligated service under that program.

It also would provide premium pay for nurses who work on Saturdays and establish a tuition reimbursement program for certain health-care professionals and require that the Chiefs of Nursing Service or their designees are active participating members of the Medical Center's policymaking committees.

Mr. Chairman, we applaud the authors of each of these measures, and again, our full support of both of those is extended to the committee.

Senator DECONCINI. Thank you, Mr. Gorman, for your fine statement. Mr. Cullinan?

[The prepared statement of Mr. Gorman appears on p. 394.]

STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you, Mr. Chairman. On behalf of the Veterans of Foreign Wars of the United States, I would like to thank you for this opportunity to present our views on these numerous pieces of legislation on veterans' health and health-related programs.

The first bill under consideration today, S. 6, the Veterans' Health-Care Improvement Act of 1987, introduced by the Chairman of the Senate Veterans' Affairs Committee, Alan Cranston, along with Senators Matsunaga, yourself sir, Mitchell, Rockefeller, Graham, and Lautenberg, contains numerous provisions pertaining to veteran's health care. It is the stated purpose of this bill to achieve these improvements in VA programs without incurring significant new costs.

The VFW is, of course, supportive of making the VA more efficient and effective so it may better serve this Nation's veterans. However, we remain concerned that the VA continue to be provided with sufficient resources to properly fulfill its mandate. As we all know, management initiatives alone will not suffice.

Section 2 of S. 6 would authorize the VA to furnish services to help a female veteran or a male veteran's spouse to achieve pregnancy in cases in which the veteran's service-connected disability impairs procreative ability. As we have stated in the past, the VFW feels that this program is long overdue, and we welcome its implementation by the VA.

Section 3 authorizes the Administrator, utilizing VA facilities, to furnish domiciliary care to a veteran who has a service-connected disability or is incapacitated from earning a living. The VFW supports this proposal. Section 4 pertains to the extension and expansion of readjustment counseling eligibility. The VFW supports this action, but we will not go into the particulars at this time for the sake of time.

Section 5 would provide for a pilot program for noninstitutional alternatives to institutional care. The VFW supports this proposal to supply health care in noninstitutional settings to eligible veterans who otherwise would be in need of VA hospital, nursing home, or domiciliary care.

Section 6 of the bill would eliminate the Administrator's authority to prescribe limitations on the furnishing of VA health care. It is a sad but well-known fact that there are those actively engaged in trying to reduce veterans' programs; and the fact that the statutory authority may exist for administrators to restrict veterans' health care is not acceptable. Thus, we support this section.

The VFW supports section 7 which would increase the authorized per diem rates to State homes for care provided to eligible veterans. Section 8 would amend section 4103 of title 38 relating to the organization of the Office of the Chief Medical Director and would establish one new position for that office. We have no objection with respect to the authorization of a maximum of two Associate Deputy Chief Medical Directors. One concern, however, is that the number of Assistant Chief Medical Directors be maintained at eight, with special emphasis on maintaining the position of Chief Medical Director for Geriatrics and Extended Care.

The VFW supports section 9 of S. 6 which would prohibit the Administrator from taking any action to declare as excess certain lands of VA Medical Centers in Southern California; its 46 acres in Sepulvada and 109 acres in West Los Angeles.

The VFW supports the 10th and final section of this bill which prescribes that, no later than March 1987, the Administrator shall submit to the committees—the Senate and House Veterans' Affairs Committees—a report regarding the VA's activities and the success of those activities. This is intended to promote increased efforts by affiliated medical and other health professional training schools in training health-care professionals to care for older patients; and we support such an action.

The next bill under consideration, S. 216, is a bill that increases per diem rates paid to States for providing care to veterans in State homes. As indicated earlier, the VFW supports such an action. S. 279, introduced by Senator DeConcini, along with Senators Cranston, Matsunaga, Mitchell, Rockefeller, and Lautenberg, calls for continued operation of VA Vet Centers, as does section 4 of S. 6 and, as mentioned earlier, enjoys the support of the VFW.

Another bill under consideration today is S. 631, the Veterans' Administration Procurement Improvement Act of 1987, sponsored by the ranking minority member of the Senate Veterans' Affairs

Committee, Senator Murkowski, along with Senators Stafford and Simpson. Inasmuch as the called-for standardized procurement policy could provide for uniformly high quality supplies throughout the VA, along with continued cost savings through competitive bidding and so forth, the VFW would not oppose this bill. Our primary concern would be that the timeliness of this procurement process and that particular medical and pharmaceutical supply needs for certain regionalized localities could be met through such a nationwide program.

Senator DECONCINI. Thank you very much. Mr. DeGeorge?

[The prepared statement of Mr. Cullinan appears on p. 415.]

STATEMENT OF FRANK R. DeGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Thank you, Mr. Chairman. It is always a privilege and an honor to appear before this committee, and we also want to thank you for the opportunity to appear here today. PVA certainly appreciates this committee's efforts to conduct this important hearing and ongoing efforts to improve VA health-care programs. And we also would like to say you sure jampacked us today. Thank you. [Laughter.]

Senator DECONCINI. I am afraid we did use the sardine approach today.

Mr. DEGEORGE. We are hanging in there with you.

Mr. Chairman, PVA does appreciate and applaud the efforts of Senator Cranston and for your support of his introduction of S. 6. PVA is particularly pleased to address the provision that provides procreative services to overcome service-connected disabilities preventing pregnancy. PVA has worked a long time to seek legislative recourse for what we merely believe is a clarification of existing VA authority.

In the future, we appreciate the opportunity to continue to work with you and your staff to bring about this necessary provision. PVA was to comment on Senator Daniel Moynihan's provision for beneficiary travel, but seeing the statement of the Chairman that he and the ranking minority have provided for beneficiary travel benefits to look at them in the future, we want to say very much that we appreciate this effort at this time; and we look forward to passage that would provide the appropriate beneficiary travel benefits to the appropriate veterans.

Mr. Chairman, PVA is also pleased to address this committee's legislative efforts to ease the acute retention and recruitment problems being experienced by the VA. We commend Senator Cranston and Senator Murkowski for their commitment to this important issue and for introduction of their two respective bills, S. 1195 and S. 713.

The Veterans' Health-Care Personnel Act of 1987 is a fine, well-crafted legislative work. This measure effectively addresses some of the VA's retention and recruitment problems while, at the same time, avoids overmanaging the agency. PVA fully supports this effort.

The provision for new pharmacists and occupational therapists into the title 38 and title 5 hybrid category would provide the VA with greater flexibility in appointments and pay matters. It would also allow these same professionals access to the health professional scholarship program and afford them the opportunity for professional advancement.

The VA needs this recruitment and retention tool in order to become a competitive employer and to increase the job satisfaction of its current employees. S. 1195 also addresses the critical nursing shortage in the VA. Providing this professional group with weekend premium pay, tuition reimbursement, and representation on all VA health-care policymaking and fiscal committees just plain makes good sense. These same benefits have been offered in the private sector and other benefits as well for a number of years.

When coupled with Senator Murkowski's bill, S. 713, the VA's Registered Nurse Variable Incentive Bonus Act of 1987, PVA believes we have the beginnings of a very good and sound legislative package and long- and short-term resolutions to the VA's professional nursing shortage.

Mr. Chairman, during your deliberations of these important health-care amendments, we would appreciate the committee's consideration of a legislative proposal to correct what PVA considers to be a basic inequity in health-care eligibility provisions. PVA testified earlier before the Congress that under current law, category A, nonservice-connected veterans, may receive outpatient treatment when it obviates the need for inpatient care is a followup to an episode of inpatient care or, according to the VA, if space is available.

There is considerable latitude in the exercise of the VA's position and judgment regarding the interpretation of obviating the need for hospitalization. PVA believes from the position of continuity of care, as well as continuity with other Federal programs, that outpatients services for category A veterans should be made an entitlement.

And on that note, I will thank you again for the time and the opportunity to appear before this committee.

[The prepared statement of Mr. DeGeorge appears on p. 428.]

Senator DeConcini. Mr. DeGeorge, thank you very much.

Gentlemen, thank you for your statements. Senator Cranston asked me to pay his particular appreciation to you for your statements, in reference to all the bills, particularly S. 6 and S. 1195, and the general unanimous support that you have given to these measures.

You know the history of this committee with the previous chairman and the present chairman that we and the staff will continue to work with you and your organization to build a legislative package here and move it forward in the next several months and see if we can't find some long-term as well as short-term solutions to some of these problems. And you play a major role in it. I wish to thank your organization leaders as well as your staff for your constructive suggestions and support of this legislation. Thank you.

The committee will stand adjourned, subject to the call of the Chairman.

[Whereupon, at 11:44 a.m., the hearing was concluded.]

APPENDIX

II

100TH CONGRESS
1ST SESSION

S. 6

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide certain new categories of persons with eligibility for readjustment counseling from the Veterans' Administration and to postpone the transition period for the Vet Center program, to authorize the establishment of a pilot program for the furnishing of noninstitutional care to certain veterans, and to increase the per diem rates paid to States for providing care to veterans in State homes; and to prohibit the excessing of certain Veterans' Administration properties; and to promote greater emphasis by affiliated health-professional training institutions on geriatric training and research; and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 6, 1987

Mr. CRANSTON (for himself, Mr. MATSUNAGA, Mr. DECONCINI, Mr. MITCHELL, Mr. ROCKEFELLER, Mr. GRAHAM, and Mr. LAUTENBERG) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide certain new categories of persons with eligibility for readjustment counseling from the Veterans' Administration and to postpone the transition period for the Vet Center program, to authorize the establishment of a pilot program for the furnishing of noninstitutional care to certain veterans, and to increase the per diem rates paid to States for providing care to veterans in State homes; and to prohibit the excessing of certain Veterans' Administration properties; and to promote greater emphasis by affiliated health-professional training institutions on geriatric training and research; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE.

(a) Short Title.—This Act may be cited as the "Veterans' Health Care Improvement Act of 1987".

(b) References to Title 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. SERVICES TO OVERCOME SERVICE-CONNECTED DISABILITIES AFFECTING PROCREATION.

Clause (A) of section 601(6) is amended to read as follows:

"(A) (i) surgical services, (ii) services to achieve pregnancy in a veteran or a veteran's spouse where such services are necessary to overcome a service-connected disability impairing the veteran's procreative ability, (iii) dental services and appliances as described in sections 610 and 612 of this title, (iv) optometric and podiatric services, (v) (in the case of a person otherwise receiving care or services under this chapter) preventive health-care services as defined in section 662 of this title, (vi) (except under the conditions described in section 612(f)(1)(A)(i) of this title) wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Administrator determines to be reasonable and necessary, and (vii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and".

SEC. 3. ELIGIBILITY FOR DOMICILIARY CARE.

(a) IN GENERAL.—Subsection (b) of section 610 is amended to read as follows:

"(b) The Administrator, through Veterans' Administration facilities, may furnish such domiciliary care as the Administrator determines is needed by a veteran for the purpose of receiving treatment or rehabilitation if the Administrator finds, pursuant to regulations which the Administrator shall prescribe, that the veteran—

"(1) has a service-connected disability, or

"(2) is incapacitated from earning a living and has no adequate means of support.".

(b) CONFORMING AMENDMENT.—Section 622(g) is amended by striking out "section 610(b)(2) and" and inserting in lieu thereof "section".

SEC. 4. READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES.

(a) EXTENSION OF ELIGIBILITY.—Section 612A(a) is amended—

(1) by inserting "(1)" before "Upon", and

(2) adding at the end the following new paragraph:

"(2)(A) Upon the request of—

"(i) a person who is serving on active duty and who also served on active duty during the Vietnam era, or

"(ii) a person (I) who is a veteran or is serving on active duty, and (II) who served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in subparagraph (B) of this subsection) occurred in such area,

the Administrator shall, within the limits of Veterans' Administration facilities, furnish counseling to assist such person in readjusting to civilian life or to active duty following service during such era or in such area.

"(B) For the purpose of subparagraph (A)(ii) of this subsection, the term 'hostilities' means a situation in which members of the Armed Forces were, as determined by the Administrator in consultation with the Secretary of Defense, subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in battle with the enemy during a period of war.".

(b) DELAY IN TRANSITION PERIOD.—Section 612A(g) is amended—

(1) in paragraph (1)(A), by striking out "centers located" and all that follows through "such health-care facilities" and inserting in lieu thereof "Vet Centers to a program providing readjustment counseling services primarily through Veterans' Administration general health-care facilities";

(2) in paragraph (2)—

(A) in subparagraph (A), by striking out "(Public Law" and all that follows through "available)"; and

(B) in subparagraph (B)—

(i) by striking out "and" at the end of clause (i);

(ii) by striking out the period at the end of clause (ii) and inserting in lieu thereof a semicolon and "and"; and

(iii) by adding at the end the following new clause:

"(iii) the Administrator's analysis and findings (focusing on veterans who served in combat) as to whether or not veterans who served on active duty during World War II or the Korean conflict could benefit from services provided under this section and, if so, the Administrator's recommendations on the most desirable means by which such services could be furnished.";

(3) in paragraph (3), by striking out "(or" and all that follows through "available)";

(4) in paragraph (4), by striking out "experience" the first place it appears and all that follows and inserting in lieu thereof "Administrator's evaluation of the experience under as much of the transition as was carried out pursuant to paragraph (1) of this subsection prior to September 30, 1989, and, based on that evaluation, the results of the study required by section 102 of the Veterans' Health Care Amendments of 1983 (Public Law 98–160), and other pertinent information regarding the readjustment counseling program, the Administrator's opinion as to the extent to which the provision of readjustment counseling services under this section through Vet Centers is needed to meet the readjustment needs of veterans who served on active duty during the Vietnam era."; and

(5) by adding at the end the following new paragraph:

"(5) In the event that the study related to post-traumatic stress disorder referred to in subparagraph (A) of paragraph (2) of this subsection is not completed in sufficient time for the Administrator to give the results of the study consideration (as required by such subparagraph) in the preparation of the report which the Administrator is required by such subparagraph to submit not later than April 1, 1987, regarding the future direction of the program for providing readjustment counseling and mental health services pursuant to this section, the dates by which such report and the reports required by paragraphs (3) and (4) of this subsection must be submitted shall be postponed by one year and the twenty-four-month period referred to in paragraph (1) of this subsection shall be deemed to be the twenty-four-month period ending on September 30, 1990. In the event that the postponements described in the preceding sentence take effect, the Administrator shall promptly publish a notification thereof in the Federal Register and promptly so advise the Committees on Veterans' Affairs of the Senate and House of Representatives.

"(6) For the purpose of this subsection—

"(A) The term 'Vet Centers' means facilities which are operated by the Veterans' Administration for the provision of services under this section and which are situated apart from Veterans' Administration general health-care facilities.

"(B) The term 'Veterans' Administration general health-care facilities' means health-care facilities operated by the Veterans' Administration for the furnishing of health-care services under this chapter, not limited to services provided through the programs established under this section.".

SEC. 5. PILOT PROGRAM OF NONINSTITUTIONAL ALTERNATIVES TO INSTITUTIONAL CARE.

(a) ESTABLISHMENT OF PILOT PROGRAM.—Subchapter 11 of chapter 17 is amended by adding at the end the following new section:

"§ 620C. Noninstitutional alternatives to institutional care; pilot program

"(a)(1) The Administrator, during the period beginning January 1, 1988, and ending December 31, 1991, and subject to subsection (c) of this section, shall conduct a pilot program under which veterans eligible under this chapter for and otherwise in need of hospital, nursing home, or domiciliary care will be furnished medical, rehabilitative, and health-related services in noninstitutional settings at not less than five nor more than ten demonstration project sites.

"(2) In selecting veterans for participation in the program, the Administrator shall accord priority to veterans who have service-connected disabilities, to veterans who are sixty-five years of age or older, to veterans who are totally and permanently disabled, and to veterans who are suffering from Alzheimer's disease or other forms of dementia.

"(b)(1)(A) In the conduct of the program, the Administrator shall (i) furnish appropriate health-related services solely through contracts with appropriate public and private agencies that provide such services, and (ii) in the case of each veteran furnished services under the program, appoint a Veterans' Administration health-care employee to furnish case management services.

"(B) For the purposes of subparagraph (A) of this paragraph, 'case management' includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration) monitoring, reassessment, and follow up.

"(2) In order to evaluate the cost-effectiveness of utilizing certain health services of agencies other than the Veterans' Administration in cases in which no Veterans' Administration facility in the vicinity of a demonstration project provides such services, the Administrator, in not more than two of the demonstration projects, may utilize appropriate health services of appropriate public and private agencies that furnish such services.

"(3) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a facility furnishing services to veterans under subparagraph (1)(A)(i) of this subsection. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the facility concerned. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds alloted to the Veterans' Administration facility that provided the assistance.

"(c) The total cost of conducting the pilot program under this section shall not exceed 60 per centum of the cost that would have been incurred by the Veterans' Administration during the period of the pilot program if the veterans furnished services under the pilot program had been furnished, instead, nursing home care under section 610 of this title. In any fiscal year, the cost of carrying out the pilot program shall not exceed 65 per centum of the cost that would have been so incurred during such year in furnishing the veterans who received services under the pilot program with nursing home care under such section 610.

"(d) Not later than April 1, 1991, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report setting forth the Administrator's evaluation, findings, and conclusions regarding the pilot program, and its results for the participating veterans, during its first thirty-six months. The report shall include a description of the conduct of the program (including a description of the veterans furnished services and of the services furnished under the pilot program), and any plans for administrative action, and any recommendations for legislation, that the Administrator considers appropriate to include in the report.".

"(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620B the following new item:

"620C. Noninstitutional alternatives to institutional care; pilot program.".

SEC. 6. RULES AND REGULATIONS RELATING TO HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE.

The text of section 621 is revised to read as follows:

"The Administrator shall prescribe all rules and regulations which are necessary and appropriate to govern the furnishing of hospital, nursing home, and domiciliary care and medical services under laws administered by the Veterans' Administration and which are consistent therewith, including such rules and regulations as are necessary and appropriate in order to promote good conduct on the part of persons who are receiving such care or services in Veterans' Administration facilities.".

SEC. 7. INCREASE IN PER DIEM RATES FOR CARE IN STATE HOMES.

Section 641(a) is amended by striking out clauses (1) through (3) and inserting in lieu thereof:

"(1) $8.70 for domiciliary care, and

"(2) $20.35 for nursing home and hospital care,".

SEC. 8. ORGANIZATION OF THE DEPARTMENT OF MEDICINE AND SURGERY.

(a) OFFICE OF THE CHIEF MEDICAL DIRECTOR.—Section 4103(a) is amended—

(1) by inserting "persons, each of whom shall be qualified in the administration of health services" after "following";

(2) in clause (3)—

(A) by striking out "The" and inserting in lieu thereof "Two";

(B) by striking out "Director" the first place it appears and inserting in lieu thereof "Directors";

(C) by striking out "an assistant" and inserting in lieu thereof "assistants";

(D) by striking out "shall be a qualified doctor of medicine" and inserting in lieu thereof "both shall be persons with specified qualifications"; and

(E) by adding at the end the following new sentence: "Not more than one Associate Deputy Chief Medical Director may be a person who is a person with specified qualifications solely by reason of clause (ii) of the last sentence of this subsection.";

(3) in clause (4)—

(A) in the first sentence, by striking out "who shall be" the first place it appears and inserting in lieu thereof "all of whom shall be persons with specified qualifications,";

(B) in the second sentence, by striking out "qualified in the administration of health services who are not doctors of medicine, dental surgery, or dental medicines" and inserting in lieu thereof "who are persons with specified qualifications solely by reason of clause (ii) of the last sentence of this subsection"; and

(C) in the last sentence, by striking out "qualified physician" and inserting in lieu thereof "person with specified qualifications";

(4) in clause (5)—

(A) by inserting a comma and "all of whom shall be persons with specified qualifications," after "Directors";

(B) by striking out the commas after "Administrator" and "Director"; and

(C) by striking out the second sentence;

(5) in clause (6), by inserting "upon the recommendation of the Chief Medical Director" after "Administrator";

(6) in clause (7)—

(A) by inserting a comma and "each of whom shall be licensed in the appropriate service field" after "Optometric Service"; and

(B) by inserting "upon the recommendation of the Chief Medical Director" after "Administrator"; and

(7) by adding at the end the following new sentence:

"For the purpose of this subsection, the term 'person with specified qualifications' means (i) a person meeting the requirements set forth in clause (1), (2), (3), (5), (6), (7), or (8) of subsection (a) of section 4105 of this title, or (ii) a person who meets or has met the requirements set forth in clause (4) of such subsection.".

(b) TECHNICAL AMENDMENT.—Section 4103(b)(3) is amended by inserting a comma after "reappointed" and after "extended" and by striking out the comma after "reappointment".

SEC. 9. PROHIBITION AGAINST EXCESSING OF CERTAIN VETERANS' ADMINISTRATION PROPERTIES.

(a) Section 234 of Public Law 99-576 is repealed.

(b) The Administrator of Veterans' Affairs may not declare as excess to the needs of the Veterans' Administration, or otherwise take any action to dispose of, the land and improvements at the Veterans' Administration Medical Center, West Los Angeles, California (consisting of approximately one hundred and nine acres), and at the Veterans' Administration Medical Center, Sepulveda, California (consisting of approximately forty-six acres), described in letters dated February 5, 1986 (and enclosed maps), from the Administrator to the Committees on Veterans' Affairs of the Senate ar

House of Representatives pursuant to section 5022(a)(2) of title 38, United States Code.

SEC. 10. REPORT ON CERTAIN ACTIVITIES RELATING TO TRAINING IN GERIATRICS OF MEDICAL AND OTHER HEALTH-PROFESSIONAL SCHOOLS AFFILIATED WITH THE VETERANS' ADMINISTRATION

(a) The Congress makes the following findings:

(1) In view of the estimate that, by the year 2030, the percentage of the United States' population that is age sixty-five and older will have risen to nearly 22 per centum from the current level of approximately 12 per centum, responding appropriately to the future health-care needs of the increasing elderly population of the United States represents one of our Nation's greatest challenges.

(2) Because veterans cluster in age groups related to periods of major conflicts, the aging of the general population is accelerated in the case of veterans, and veterans of War II and the Korean conflict will enter in the near future the age range with the greatest need for health and health-related services and constitute a very significant portion of the total veteran population.

(3) In response to the needs of the growing number of older veterans, the Veterans' Administration, pursuant to Congressional guidance and direction, has increased its ef-

forts with respect to the development of new approaches to furnishing such care, the training of health-care professionals in the care of older patients, and the carrying out and funding of research into diseases and disabilities associated with aging and into the aging process.

(4) As a result of the Veterans' Administration's affiliation arrangements with one hundred and one medical schools, fifty-nine dental schools, approximately five hundred nursing schools, and approximately three hundred and fifty other health-care professional training institutions through which over one hundred thousand students and trainees receive training in Veterans' Administration facilities annually and the important role which those arrangements fulfill in those schools carrying out their education and training missions, the Veterans' Administration has a vital opportunity to improve efforts to train health-care professionals in the care of older patients and to heighten research activity into diseases and disabilities associated with aging and into the aging process.

(5) As an indication of the importance of the Veterans' Administration's role in promoting efforts by affiliated health-care professional training institutions, the Congress in Public Law 96-330, provided that no Veterans' Administration medical center could be designated as the site for a Geriatric Research, Education, and Clinical Center—centers of excel-

lence in the area of aging research, education, and treatment—unless the Veterans' Administration medical center has arrangements with affiliated schools which provide education and training in geriatrics and which provide medical residents and nursing or allied health personnel with training and education in geriatrics through regular rotation through all bed components of the Veterans' Administration medical center.

(b)(1) In light of the findings in subsection (a), not later than March 1, 1987, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding the Veterans' Administration's activities, and the success of those activities, designed to promote increased efforts by affiliated medical and other health-professional training schools (1) in training heath-care professionals to care for older patients, and (2) in research into the aging process and diseases and disabilities associated with aging.

(2) The report shall include—

(A) information, for each academic year from 1980–1981 through 1986–1987, on the number of institutions affiliated with the Veterans' Administration (hereinafter in this paragraph referred to as "affiliated institutions"), broken down by type of institution and type of training, that—

(i) have a program through which students or trainees receive education and training in geriatrics through regular rotation through Veterans' Administration medical centers, nursing homes, domiciliary care facilities, or other units providing extended care to veterans; or

(ii) have a formal program providing education and training in geriatrics; or

(iii) have both such programs;

(B) information on the number of affiliated institutions (broken down by type of institution) that are planning to establish programs as described in subparagraph (A), together with a timetable for such actions;

(C) estimates to the costs, both to the Veterans' Administration and to the affiliated institutions, of the programs described in subparagraphs (A) and (B);

(D) estimates of the number of Veterans' Administration patients receiving care or who will receive care from the students or trainees participating in programs described in subparagraphs (A)(i) and (B);

(E) a description of the role of the Veterans' Administration in encouraging the establishment and continuation of the programs described in subparagraph (A); and

(F) the views of the Administrator on the feasibility and desirability of requiring, as a condition of the Veterans' Administration's entering into or continuing an affiliation agreement with a health-care professional training institution, the establishment with such institution of the appropriate type of arrangements described in subparagraph (C) (i) or (ii) of section 4101(f) of title 38, United States Code.

II

100TH CONGRESS
1ST SESSION

S. 105

To amend title 38, United States Code, to provide for the payment of incentive special pay to Veterans' Administration psychologists who obtain certain board certification in a professional specialty.

IN THE SENATE OF THE UNITED STATES

JANUARY 6, 1987

Mr. INOUYE introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to provide for the payment of incentive special pay to Veterans' Administration psychologists who obtain certain board certification in a professional specialty.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) subchapter I of chapter 73 of title 38, United States Code, is amended—

(1) by redesignating section 4119 as section 4120; and

(2) by inserting after section 4118 the following new section:

"§ 4119. Incentive special pay for psychologists

"(a) The Administrator shall pay incentive special pay to any psychologist appointed under this chapter who—

"(1) executes an agreement with the Administrator to complete a specified period of service in the Department of Medicine and Surgery; and

"(2)(A) is awarded a diploma as a Diplomate in Clinical Psychology or as a Diplomate in Counseling Psychology by the American Board of Professional Psychology; or

"(B) obtains an additional advanced academic degree, such as a masters degree in public health, which the Administrator determines is in the best interest of the Veterans' Administration.

"(b)(1) The amount of incentive special pay which the Administrator pays to any psychologist under this section may not exceed—

"(A) $2,500 per annum in the case of any full-time psychologist; and

"(B) a proportional amount of $1,500 per annum in the case of any part-time psychologist, as provided under paragraph (2) of this paragraph.

"(2) The proportional amount of the incentive special pay payable under paragraph (1)(B) of this subsection shall be calculated on the basis of the ratio which the part-time employment of such psychologist in the Department of Medicine and Surgery bears to full-time employment.

"(c)(1) Any agreement entered into by a psychologist under subsection (a)(1) of this section shall specify a period of one year of service in the Department of Medicine and Surgery or such longer period of service, not exceeding four years, as the psychologist requests. Any psychologist who has entered into an agreement under this section and has not failed to refund any amount which such psychologist became obligated to refund under any such agreement shall be eligible to enter into a subsequent agreement under this section.

"(2)(A) Any agreement entered into by a psychologist under subsection (a)(1) of this section shall provide that the psychologist, in the event that such psychologist voluntarily, or because of misconduct, fails to complete at least one year of service, or such longer period of service as is provided for in the first sentence of paragraph (1) of this subsection, pursuant to such agreement, shall be required to refund the total amount received under this section, unless the Chief Medical Director determines, in accordance with regulations prescribed under subsection (f) of this section, that such failure is necessitated by circumstances beyond the control of the psychologist.

"(B) Any such agreement shall specify the terms under which the Veterans' Administration and the psychologist may elect to terminate such agreement.

"(3) Any psychologist who enters into an agreement under this section is eligible to receive incentive special pay beginning on the date on which the agreement is entered into, or the date on which the psychologist becomes employed, whichever date is later.

"(d) Any amount of incentive special pay payable under this section shall be paid in biweekly installments.

"(e)(1) Except as provided in paragraphs (2) and (3) of this subsection, any additional compensation provided as incentive special pay under this section shall not be considered as basic pay for the purposes of sections 5551, 5552, and 5595 of title 5, chapters 81, 83, and 84 of such title, or any other provision of law creating an entitlement to benefits based on basic pay.

"(2) Additional compensation paid as incentive special pay under this section to any full-time employee shall be included in basic pay for the purposes of chapters 83 and 84 of title 5. Notwithstanding the preceding sentence, special pay paid to any full-time employee shall be included in average pay (as defined in section 8331(4) or 8401(3), as the case may be, of such title) for the purposes of computing the amount of any benefit under either such chapter only if—

"(A) the benefit is paid under section 8337 of such title, subsection (d) or (e) of section 8341 of such title, subchapter V of chapter 84 of such title, or section 8442(b), 8443(a), or 8445 of such title; or

"(B) the employee has completed not less than 15 years of full-time service in the Department of Medicine and Surgery (except that, regardless of the length of such employee's service, no incentive special pay may be included by reason of this clause in average pay in computing an annuity that commences (or any lump-sum payment that is payable) before October 1, 1988, and only one-half of any incentive special pay paid under this section may be included by reason of this clause in average pay in computing an annuity that commences (or any lump-sum payment that is payable) on or after October 1, 1988, but before October 1, 1993).

"(3) Any additional compensation provided as incentive special pay under this section shall be considered as annual pay for the purposes of chapter 87 of title 5, relating to life insurance for Federal employees.

"(f) The Administrator shall prescribe regulations to carry out this section.".

(b) The table of sections at the beginning of such chapter is amended by striking out the item relating to section 4119 and inserting in lieu thereof the following:

"4119. Incentive special pay for psychologists.
"4120. Relationship between this subchapter and other provisions of law.".

SEC. 2. The amendments made by the first section shall take effect on October 1, 1987.

II

100TH CONGRESS
1ST SESSION

S. 216

To amend title 38, United States Code, to increase the per diem rates paid to States for providing care to veterans in State homes.

IN THE SENATE OF THE UNITED STATES

JANUARY 6, 1987

Mr. MITCHELL (for himself, Mr. CRANSTON, and Mr. MATSUNAGA) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to increase the per diem rates paid to States for providing care to veterans in State homes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 641(a) of title 38, United States Code, is amended by striking out clauses (1) through (3) and inserting in lieu thereof: "(1) $8.70 for domiciliary care, and "(2) $20.35 for nursing home and hospital care,".

II

100TH CONGRESS
1ST SESSION

S. 631

To improve the procedures for the procurement of medical and pharmaceutical supplies by the Veterans' Administration.

IN THE SENATE OF THE UNITED STATES

MARCH 3, 1987

Mr. MURKOWSKI (for himself, Mr. STAFFORD, and Mr. SIMPSON) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To improve the procedures for the procurement of medical and pharmaceutical supplies by the Veterans' Administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans' Administration Procurement Improvement Act of 1987".

SEC. 2. STANDARDIZATION OF MEDICAL AND PHARMACEUTICAL SUPPLIES PROCUREMENT.

Not later than 3 years after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall develop and fully implement an agency-wide plan for the standardization of all medical and pharmaceutical supplies procured by the Veterans' Administration. The plan shall provide for the procurement of generic medical and pharmaceutical supplies.

SEC. 3. REQUIREMENTS FOR THE PROCUREMENT OF MEDICAL AND PHARMACEUTICAL SUPPLIES.

(a) IN GENERAL.—Subchapter II of chapter 81 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 5025. Procurement of medical and pharmaceutical supplies

"(a) Except as provided in subsection (b) of this section, the Veterans' Administration shall procure medical and pharmaceutical supplies only under national contracts awarded by the Veterans' Administration.

"(b)(1) Subject to paragraph (2) of this subsection, a Veterans' Administration medical center may procure a medical or pharmaceutical item or a supply of such an item under a local contract instead of a national contract awarded by the Veterans' Administration only if the medical center has an emergency need for that item or supply or that item or supply is not available under a national contract. In the case of a procurement to meet an emergency need, a medical center may procure only the quantity of the medical or pharmaceutical item or supply necessary to meet that need.

"(2) Not more than 20 percent of the medical and pharmaceutical supplies procured by the Veterans' Administration medical centers in any fiscal year (measured as a percent of the total cost of all medical and pharmaceutical supplies procured by the medical centers in that fiscal year) may be procured under local contracts.

"(c) The Administrator shall award, in the case of each Veterans' Administration medical center, a contract or contracts for the procurement of a medical and pharmaceutical item or supply of such an item to a person or persons regularly engaged in the wholesale supply of medical and pharmaceutical supplies in the medical and pharmaceutical supplies marketing area in which that medical center is located.

"(d) Any provision of law that is inconsistent with subsections (a), (b), and (c) of this section shall not apply, to the extent of the inconsistency, to the procurement of medical and pharmaceutical supplies by the Veterans' Administration.

"(e) At the beginning of each fiscal year, the medical center director of each Veterans' Administration medical center shall transmit to the Administrator a report containing a list and the quantity of all medical and pharmaceutical items or supplies procured by that medical center under a local contract during the preceding fiscal year.

"(f) For the purposes of this section, the term 'local contract' means a contract awarded under subsection (c) of this section.".

(b) CONFORMING AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 5024 the following new item:

"5025. Procurement of medical and pharmaceutical supplies.".

(c) APPLICATION.—Subsection (b)(2) of section 5025 of title 38, United States Code (as added by subsection (a)) shall apply to medical and pharmaceutical supplies procured by the Veterans' Administration medical centers on or after October 1, 1990.

II

100TH CONGRESS
1ST SESSION

S. 713

To amend title 38, United States Code, to facilitate the recruitment of registered nurses by the Veterans' Administration.

IN THE SENATE OF THE UNITED STATES

MARCH 11, 1987

Mr. MURKOWSKI introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to facilitate the recruitment of registered nurses by the Veterans' Administration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans' Administration Registered Nurse Variable Incentive Bonus Act of 1987".

SEC. 2. RECRUITMENT AND RETENTION PAY.

(a) IN GENERAL.—Subchapter I of chapter 73 of title 38, United States Code, is amended—

(1) in section 4107(d), by striking out "section 4118" and inserting in lieu thereof "sections 4118 and 4119";

(2) by redesignating section 4119 as section 4120; and

(3) by inserting after section 4118 the following new section:

"§ 4119. Recruitment and retention pay for registered nurses

"(a) Notwithstanding any other provision of law, in order to recruit and retain highly qualified registered nurses for which there is a critical shortage in the Department of Medicine and Surgery, the Administrator shall pay a bonus to any registered nurse as provided in this section and in regulations prescribed by the Administrator under subsection (j) of this section.

"(b) The Administrator shall pay a bonus, in any amount not to exceed $20,000, to any registered nurse appointed under this chapter who executes a written agreement with the Administrator—

"(1) to be employed on a full-time basis in the Department of Medicine and Surgery for a specified period of service not less than 3 years; and

"(2) to serve during that period at a specific geographic location or in a professional specialty for which the Administrator has determined under subsection (f) of this section that there are significant recruitment and retention problems unless the Administrator assigns such nurse to serve in another specific geographic location or professional specialty during that period.

"(c) A bonus may not be paid under this section to any registered nurse who has received a training scholarship which obligates such nurse to serve in the Veterans' Administration for a specified period of employment.

"(d) A bonus under this section may be paid, in connection with an agreement entered into under this section, in a lump sum at the time the agreement is executed or in installments throughout the period of obligated service specified in the agreement.

"(e) A bonus paid to any registered nurse under this section shall be in addition to any pay or allowance to which such nurse is entitled.

"(f) At least once each year the Administrator shall determine the specific geographic locations and professional specialties, if any, in which there are significant problems recruiting and retaining registered nurses to serve.

"(g) Any registered nurse who has entered into an agreement under this section and has not failed to refund any amount which such nurse became obligated to refund under subsection (h) of this section shall be eligible to enter into a subsequent agreement under this section.

"(h)(1) Any registered nurse who receives a bonus payment under this section and who voluntarily, or because of misconduct, fails to perform services as assigned by the Administrator for the period provided in the agreement shall refund to the United States Treasury the amount computed under paragraph (2) of this subsection, unless the Administrator determines, in accordance with regulations prescribed under subsection (j) of this section, that such failure is necessitated by circumstances beyond the control of such nurse.

"(2) The amount required to be refunded by a nurse under paragraph (1) of this subsection is the amount equal to the excess, if any, of—

"(A) the total amount of the bonus paid to such nurse under this section, over

"(B) the amount that bears the same ratio to the total amount of the bonus agreed to be paid to such nurse under this section as the period that such nurse performed services as assigned by the Administrator bears to the total period of service provided in the agreement.

"(3) An obligation to refund any portion of a bonus payment under this subsection is, for all purposes, a debt owed to the United States.

"(i) The amount of any bonus paid under this section shall not be considered as basic pay for the purposes of sections 5551, 5552, and 5595 of title 5, chapters 81, 83, 84, and 87 of such title, or any other provision of law creating an entitlement to benefits based on basic pay.

"(j) The Administrator shall prescribe regulations to carry out this section.".

(b) CONFORMING AMENDMENT.—The table of sections at the beginning of such chapter is amended by striking out the item relating to section 4119 and inserting in lieu thereof the following:

"4119. Recruitment and retention pay for registered nurses.
"4120. Relationship between this subchapter and other provisions of law.".

SEC. 3. EFFECTIVE DATE.

The amendments made by section 2 shall take effect on October 1, 1987.

II

100TH CONGRESS
1ST SESSION

S. 894

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to furnish certain hospital care and medical services for service-connected disabilities of certain veterans.

IN THE SENATE OF THE UNITED STATES

APRIL 1 (legislative day, MARCH 30), 1987

Mr. MURKOWSKI introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to furnish certain hospital care and medical services for service-connected disabilities of certain veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 624(b) of title 38, United States Code, is amended by striking out "(1) is a citizen of the United States sojourning or residing abroad, or (2) is in the Republic of the Philippines." and inserting in lieu thereof "is sojourning or residing abroad.".

100TH CONGRESS
1ST SESSION

S. 1195

To amend title 38, United States Code, to provide authorities to help the Veterans' Administration overcome difficulties in the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other health-care personnel in its Department of Medicine and Surgery; and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 12 (legislative day, MAY 8), 1987

Mr. CRANSTON (for himself, Mr. MURKOWSKI, Mr. MATSUNAGA, Mr. DECONCINI, Mr. MITCHELL, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to provide authorities to help the Veterans' Administration overcome difficulties in the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other health-care personnel in its Department of Medicine and Surgery; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCE TO TITLE 38, UNITED STATES CODE.

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Administration Health-Care Personnel Act of 1987".

(b) REFERENCES TO TITLE 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. MAKING NURSE ADDITIONAL-PAY AUTHORITIES AVAILABLE TO ASSIST IN RECRUITMENT AND RETENTION OF PHARMACISTS AND OCCUPATIONAL THERAPISTS.

(a) Section 4104 is amended—

(1) in paragraph (2), by striking out "Pharmacists" and all that follows through "therapists" and inserting in lieu thereof "Psychologists (other than those described in paragraph (3) of this section)"; and

(2) in paragraph (3)—

(A) by striking out "and"; and

(B) by inserting after "nurses" a comma and "pharmacists, and occupational therapists".

(b) Section 4107(f) is amended in the second sentence—

(1) by striking out "or licensed" and inserting in lieu thereof "licensed"; and

(2) inserting "pharmacists, or occupational therapists," after "nurses".

SEC. 3. PREMIUM PAY FOR SATURDAY WORK.

Section 4107(e) is amended—

(1) in paragraph (3), by striking out "Saturday" and inserting in lieu thereof "Friday"; and

(2) in paragraph (10)—

(A) in subparagraph (A), by striking out "Administrator—" and all that follows and inserting in lieu thereof "Administrator may increase the rates of additional pay authorized under paragraphs (2) through (8) of this subsection.";

(B) in subparagraph (B), by striking out "(A)(i)" and inserting in lieu thereof "(A)"; and

(C) by repealing subparagraph (C).

SEC. 4. NURSE REPRESENTATION.

Section 4112 is amended by adding at the end the following new subsection:

"(c) The Administrator shall require that the Chief of Nursing Service, or the designee of the Chief, at each Veterans' Administration health-care facility be included in the membership of each policymaking and fiscal committee at each such facility including, but not limited to (1) committees relating to (A) budget, (B) education, (C) position management, (D) clinical executive issues, (E) planning, and (F) resource allocation, and (2) the deans committee or other advisory committee established pursuant to subsection (b) of this section.".

SEC. 5. EDUCATIONAL ASSISTANCE PROGRAM.

(a) Subchapter IV of chapter 73 is repealed.

(b) Part V is amended by adding at the end the following new chapter:

"CHAPTER 76—VETERANS' ADMINISTRATION HEALTH PROFESSIONAL EDUCATIONAL ASSISTANCE PROGRAM

"SUBCHAPTER I—GENERAL

"Sec.
"4301. Establishment of program; purpose.
"4302. Eligibility; application; written contract.
"4303. Breach of contract; liability; waiver.
"4304. Exemption of educational assistance payments from taxation.
"4305. Program subject to availability of appropriations.

"SUBCHAPTER II—VETERANS' ADMINISTRATION HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM

"4311. Duration of program.
"4312. Eligibility; application; written contract.
"4313. Obligated service.
"4314. Breach of contract; liability.

"SUBCHAPTER III—VETERANS' ADMINISTRATION HEALTH PROFESSIONAL TUITION REIMBURSEMENT PROGRAM

"4321. Eligibility; application; written contract.
"4322. Obligated service.
"4323. Breach of contract; liability.
"4324. Allocation and distribution of funding.

SUBCHAPTER I—GENERAL

"§ 4301. Establishment of program; purpose

"There is hereby established a program to be known as the Veterans' Administration Health Professional Educational Assistance Program (hereinafter in this chapter referred to as the "Educational Assistance Program"), which shall comprise (1) a scholarship program as provided for in subchapter II of this chapter, to be known as the Veterans' Administration Health Professional Scholarship Program (hereinafter in this chapter referred to as the "Scholarship Program"), and (2) a tuition reimbursement program as provided for in subchapter III of this chapter, to be known as the Veterans' Administration Health Professional Tuition Reimbursement Program (hereinafter in this chapter referred to as the "Tuition Reimbursement Program"). The purpose of the Educational Assistance Program is to assist in providing an adequate supply of trained health-care personnel who provide either direct patient-care services or services incident to direct patient-care services for the Veterans' Administration and for the Nation.

"§ 4302. Eligibility; application

"(a) To be eligible to participate in the Educational Assistance Program, an individual, in addition to meeting the criteria specified in section 4312 of this title for participation in the Scholarship Program or in section 4321 of this title for participation in the Tuition Reimbursement Program, must—

"(1) be accepted for enrollment or be currently enrolled as a student (A) in an accredited (as determined by the Administrator) educational institution in a

State, and (B) in a course of training offered by such institution and approved by the Administrator, leading toward completion of any degree in an appropriate discipline (as determined by the Administrator);

"(2) submit an application to the Administrator for participation in the Educational Assistance Program;

"(3) sign and submit to the Administrator, at the time of submission of such application, a written contract (described in subsection (e) of this section) to accept payment of educational assistance and to serve a period of obligated service as provided in section 4313 of this title for the scholarship program or in section 4322 of this title for the Tuition Reimbursement Program; and

"(4) at the time of submission of such application, not be obligated under any other Federal program to perform service after completion of the course of study or program of such individual referred to in clause (1) of this subsection.

"(b)(1) In distributing application forms and contract forms to individuals desiring to participate in the Educational Assistance Program, the Administrator shall include with such forms—

"(A) a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Administrator, including in the summary a clear explanation of the damages to which the United States is entitled under section 4314 of this title with respect to the Scholarship Program or section 4323 of this title with respect to the Tuition Reimbursement Program, is the individual breaches the contract; and

"(B) a full description of the terms and conditions that would apply to the individual's participation in the Educational Assistance Program and service in the Department of Medicine and Surgery.

"(2) The Administrator shall make such application forms and other information available to individuals desiring to participate in the Educational Assistance Program on a date sufficiently early to allow such individuals adequate time to prepare and submit such forms.

"(c) In selecting applicants for acceptance in the Educational Assistance Program, the Administrator, in addition to according priority as set forth in section 4312(b)(1) of this title with respect to the Scholarship Program or in section 4321(b) of this title with respect to the Tuition Reimbursement Program, shall give priority to the applications of individuals who have previously received educational assistance under this program and have not completed the program of education undertaken under such section.

"(d)(1) An individual becomes a participant in the Educational Assistance Program only upon the Administrator's approval of the indivdual's application submitted under subsection (a)(2) of this section and the Administrator's acceptance of the contract signed by the individual under subsection (a)(3) of this section.

"(2) The Administrator shall provide written notice to an individual promptly upon the Administrator's approval under paragraph (1) of this subsection of the individual's participation in the Educational Assistance Program.

"(e) The written contract (referred to in subsection (a)(3) of this section) between the Administrator and a participant in the Educational Assistance Program, in addition to the provisions specified in section 4312(b) of this title with respect to the Scholarship Program or in section 4321(d) of this title with respect to the Tuition Reimbursement Program, shall contain—

"(1)(A) subject to clause (2) of this subsection, the Administrator's agreement—

"(i) to provide the participant with educational assistance as authorized in this chapter and specified in the agreement, and "(ii) to afford the participant the opportunity for employment in the Department of Medicine and Surgery (subject to the availability of appropriated funds for such purpose and other qualifications established in accordance with section 4105 of this title); and

"(B) subject to clause (2) of this subsection, the participant's agreement—

"(i) to accept such educational assistance;

"(ii) to maintain enrollment and attendance in the course of training until completed; and

"(iii) while enrolled in such course, to maintain an acceptable level of academic standing (as determined by the educational institution offering such course of training under regulations prescribed by the Administrator);

"(2) a provision that any financial obligation of the United States arising out of a contract entered into under this chapter, and any obligation of the participant which is conditioned thereon, is contingent upon funds being appropriated for educational assistance under this chapter;

"(3) a statement of the damages to which the United States is entitled under section 4314 of this title with respect to the Scholarship Program or section 4323 of this title with respect to the Tuition Reimbursement Program, for the participant's breach of the contract; and

"(4) such other statements of the rights and liabilities of the Administrator and of the participant as may be appropriate and consistent with the provisions of this chapter.

"(f) The maximum amount of (1) the monthly stipend paid to a participant in the Scholarship Program, specified in section 4312(d)(1)(B) of this title and as previously adjusted (if at all) in accordance with this subsection, and (2) the maximum amount of tuition reimbursement provided to a participant in the Tuition Reimbursement Program, specified in section 4321(e) of this title and as previously adjusted (if at all) in accordance with this subsection, shall be increased by the Administrator for each school year ending in a fiscal year beginning after September 30, 1988, by an amount (rounded to the next highest multiple of $1) equal to the amount of such stipend or tuition reimbursement multiplied by the overall percentage (as set forth in the report transmitted to the Congress under section 5305 of title 5) of the adjustment (if such adjustment is an increase) in the rates of pay under the General Schedule made effective in the fiscal year in which such school year ends.

"(g) The Administrator shall report to Congress not later than March 1 of each year—

"(1) the number of students receiving educational assistance under the Educational Assistance Program, broken down to show the numbres of students receiving assistance under the Scholarship Program and the Tuition Reimbursement Progam separately, and the number of students enrolled in each type of health profession training under each program;

"(2) the education institutions providing such training to students in each program;

"(3) the number of applications filed under each program, by health profession category, during the school year beginning in such year and the total number of such applications so filed for all years in which the Educational Assistance Program (or predecessor program) has been in existence;

"(4) the average amounts of educational assistance provided per participant in the Scholarship Program and per participant in the Tuition Reimbursement Program;

"(5) the amount of tuition and other expenses paid, by health profession category, in the aggregate and at each educational institution for the school year beginning in such year and for prior school years;

"(6) the number of scholarships accepted, by health profession category, during the school year beginning in such year and the number, by health profession category, which were offered and not accepted; and

"(7) the number of participants who complete a course or course of training in each program each year and for all years such program (or predecessor program) has been in existence.

"(h) The Administrator shall prescribe regulations to carry out the Educational Assistance Program.

"§ 4303. Breach of contract; liability; waiver

"(a)(1) Any obligation under the Educational Assistance Program (or a written contract thereunder) of a participant in the Educational Assistance Program for service or payment of damages shall be canceled upon the death of the participant.

"(2) The Administrator shall prescribe regulations providing for the waiver or suspension of any obligation of a participant for service or payment under such Program (or a contract thereundre) whenever compliance by the participant is impossible due to circumstances beyond the control of the participant or whenever the Administrator determines that the waiver or suspension of compliance would be in the best interest of the Veterans' Administration.

"(3) Any obligation of a participant under such Program (or a contract thereunder) for payment of damages may not be released by a discharge in bankruptcy under title 11 before the expiration of the five-year period beginning on the first date the payment of such damages is due.

"(b) The Administrator, in cooperation with and with the consent of the heads of other relevant departments and agencies and with the consent of the participant or individual involved, may permit—

"(1) any period of obligated service required to be performed under this chapter to be performed in another Federal department or agency or in the Armed Forces; and

"(2) any period of obligated service required to be performed in another Federal department or agency or in the Armed Forces under another Federal health personnel educational assistance program to be performed in the Department of Medicine and Surgery.

"§ 4304. Exemption of educational assistance payments from taxation

"Notwithstanding any other law, any payment to, or on behalf of a participant in the Educational Assistance Program, for tuition, education expenses, or a stipend under this chapter shall be exempt from taxation.

"§ 4305. Program subject to availability of appropriations

"The authority of the Administrator to make payments under this chapter is effective for any fiscal year only to the extent that appropriated funds are available for such purposes.

"SUBCHAPTER II—VETERANS' ADMINISTRATION HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM

"§ 4311. Duration of program

"The Administrator may not furnish scholarships to new participants in the Scholarship Program after September 30, 1992.

"§ 4312. Eligibility; application; written contract

"(a) To be eligible to participate in the Scholarship Program, an individual, in addition to meeting the requirements specified in section 4302 of this title, must be accepted for enrollment or be enrolled (as described in clause (1) of section 4302(a) of this title) as a full-time student, except that an individual who is a Veterans' Administration employee described in subsection (e)(1) of this section may be accepted as a participant if accepted for enrollment or enrolled (as described in clause (1) of section 4302(a) of this title) for study on less than a full-time but not less than a half-time basis. (Such a participant is hereinafter in this subchapter referred to as a "part-time student".)

"(b)(1) In selecting applicants who are pursuing a course of training in nursing for acceptance in the Scholarship Program, the Administrator, in addition to according priorities as set forth in section 4302(c) of this title, shall give priority to the applications of individuals who have completed three years of a four-year course of training leading to a baccalaureate degree.

"(2) Before awarding the initial scholarship in any course of training other than in medicine or nursing, the Administrator, not less than sixty days before awarding such scholarship, shall notify the Committees on Veterans' Affairs of the Senate and House of Representatives of the Administrator's intent to award a scholarship in such course of training and of the reasons why the award of scholarships in such course of training is necessary to assist in providing for the Veterans' Administration an adequate supply of personnel in the health profession concerned.

"(c) The written contract referred to in section 4302(a)(3) of this title between the Administrator and a participant in the Scholarship Program, in addition to the requirements set forth in such section, shall contain—

"(1) the Administrator's agreement, subject to section 4302(e)(2) of this title, to provide the participant with a scholarship (described in subsection (d) of this section) for from one to four school years (or in a case in which an extension is granted under subsection (e)(3) of this section, the number of school years provided for as a result of such extension) during which period the participant is pursuing a course of training described in section 4302(a)(1)(B) of this title; and

"(2) subject to section 4302(e)(2) of this title, the participant's agreement—

"(A) to serve as a full-time employee in the Department of Medicine and Surgery for a period of time (hereinafter in this subchapter referred to as the 'period of obligated service') of two calendar years for each school year or part thereof for which the participant was provided a scholarship under the Scholarship Program (to be reduced, in the case of a participant who is a part-time student, in accordance with the proportion that the number of credit hours carried by such participant in any such school year bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant, but in no event, to less than one year);

"(B) if the participant's period of obligated service is deferred under section 4313(b)(3)(A)(i) of this title, to serve any additional period of obligated service prescribed by the Administrator under section 4313(b)(4)(B) of this title; and

"(C) in the case of a participant who is a part-time student, to maintain employment, while enrolled in such course of training, as a Veterans' Administration employee permanently assigned to a Veterans' Administration health-care facility.

"(d)(1) A scholarship provided to a participant in the Scholarship Program for a school year under a written contract under the Scholarship Program shall consist of—

"(A) payment to, or (in accordance with paragraph (2) of this subsection) on behalf of, the participant of the amount of—

"(i) the tuition of the participant in such school year; and

"(ii) other reasonable educational expenses, including fees, books, and laboratory expenses; and

"(B) payment to the participant of a stipend of not in excess of $485 per month (adjusted in accordance with section 4302(f) of this title) for each of the twelve consecutive months beginning with the first month of such school year, except that a stipend may not be paid to a participant who is a full-time employee of the Veterans' Administration and the stipend of a participant who is a part-time student shall be adjusted as provided in subsection (e)(2) of this section.

"(2) The Administrator may contract with an educational institution in which a participant in the Scholarship Program is enrolled for the payment to the educational institution of the amounts of tuition and other reasonable educational expenses described in paragraph (1)(A) of this subsection. Payment to such an educational institution may be made without regard to subsections (a) and (b) of section 3324 of title 31.

"(e)(1) To be accepted as a participant as a part-time student, an individual must be a full-time Veterans' Administration employee permanently assigned to a Veterans' Administration health-care facility on the date on which such individual submits the application referred to in subsection (a)(2) of section 4302 of this title and on the date on which such individual becomes a participant in the Scholarship Program.

"(2) If a participant in the Scholarship Program is awarded a scholarship as a part-time student—

"(A) the maximum amount of the stipend payable to such participant under subsection (d)(1)(B) of this section shall be reduced in accordance with the proportion that the number of credit hours carried by such participant bears to the number of credit hours required to be carried by a full-time student in the course of training being pursued by the participant; and

"(B) a stipend may not be paid to such a participant under such subsection for any month during which such participant is not actually attending the course of training in which such participant is enrolled.

"(3) In the case of a participant who is a part-time student, the Administrator may extend the scholarship award period to a maximum of 6 school years if the Administrator determines that such an extension would be in the best interest of the United States.

"(f) Notwithstanding any other provision of law, participants in the Scholarship Program shall not by virtue of their participation in such program (1) be considered to be employees of the Federal Government, or (2) be counted against any personnel ceiling affecting the Department of Medicine and Surgery.

"§ 4313. Obligated service

"(a) Each participant in the Scholarship Program shall provide service in the full-time clinical practice of such participant's profession or in another health-care position, in an assignment or location as determined by the Administrator, as a full-time employee of the Veterans' Administration for the period of obligated service provided in the contract of such participant entered into under section 4302(a)(3) of this title.

"(b)(1) Not later than sixty days prior to (A) the date described in paragraph (3) of this subsection with respect to a participant in the Scholarship Program who is a full-time student, or (B) the date provided for under paragraph (5) of this subsection with respect to a participant who is a part-time student, the Administrator shall notify the participant of the date described in the applicable such paragraph for the beginning of such participant's period of obligated service.

"(2) As soon as possible after the applicable date described in paragraph (3) of this subsection or provided for under paragraph (5) of this subsection, the Administrator shall—

"(A) in the case of a participant who is not a full-time employee in the Department of Medicine and Surgery, appoint such participant as such an employee; and

"(B) in the case of a participant who is such an employee but is not serving in a position for which such participant's course of training prepared such participant, assign such participant to such a position.

"(3)(A)(i) With respect to a participant receiving a degree from a school of medicine, osteopathy, dentistry, optometry, or podiatry, the date for the beginning of the participant's period of obligated service is the date upon which the participant becomes licensed to practice medicine, osteopathy, dentistry, optometry or podiatry, as the case may be, in a State, except that the Administrator may, at the request of such participant, defer such date until the end of the period of time required for the participant to complete an internship or residency or other advanced clinical training. If the participant requests such a deferral, the Administrator shall notify the participant that such deferral could lead to an additional period of obligated service in accordance with paragraph (4) of this subsection.

"(ii) No such period of internship or residency or other advanced clinical training shall be counted toward satisfying a period of obligated service under this subchapter.

"(B) With respect to a participant receiving a degree from a school of nursing, the date for the beginning of the participant's period of obligated service is the later of (i) the date upon which the participant completes such participant's courses of training, or (ii) the date upon which the participant becomes registered as a graduate nurse in a State.

"(C) With respect to a participant receiving a degree from an institution other than a school of medicine, osteopathy, dentistry, optometry, podiatry, or nursing, the date for the beginning of the participant's period of obligated service is the date upon which the participant completes the course of training leading to such degree.

"(4) Any participant whose period of obligated service is deferred under paragraph (3)(A) of this subsection—

"(A) shall be required to undertake internship or residency or other advanced clinical training in an accredited program in an educational institution which is an affiliated institution (as defined in section 4108(c)(1) of this title) and with respect to which the affiliation agreement provides that all or part of the internship or residency or other advanced clinical training will be undertaken in a Veterans' Administration health-care facility; and

"(B) may, at the discretion of the Administrator and upon the recommendation of the Chief Medical Director, incur an additional period of obligated service—

"(i) at the rate of one-half of a calendar year for each year of internship or residency or other advanced clinical training (or a proportionate ratio thereof), if the internship, residency, or advanced clinical training is in a medical specialty necessary to meet the health care requirements of the Veterans' Administration (as determined under regulations prescribed by the Administrator); or "(ii) at the rate of three-quarters of a calendar year for each year of internship or residency or other advanced clinical training (or a proportionate ratio thereof), if the internship, residency, or advanced clinical training is not in a medical specialty necessary to meet the health care requirements of the Veterans' Administration (as determined under regulations prescribed by the Administrator).

"(5) The Administrator shall by regulation prescribe the date for the beginning of the period of obligated service of a participant who was a part-time student. Such regulations shall prescribe terms as similar as practicable to the terms set forth in paragraph (3) of this subsection.

"(c)(1) Except as provided in paragraph (2) of this subsection, a participant in the Scholarship Program shall be considered to have begun serving such participant's period of obligated service—

"(A) on the date, after such participant's course completion date, on which such participant (in accordance with subsection (a) of this section) is appointed under this chapter as a full time employee in the Department of Medicine and Surgery; or

"(B) if the participant is a full-time employee in the Department of Medicine and Surgery on such course completion date, on the date thereafter on which such participant is assigned to a position for which such participant's course of training prepared such participant.

"(2) A participant in the Scholarship Program who on such participant's course completion date is a full-time employee in the Department of Medicine and Surgery serving in a capacity for which such participant's course of training prepared such participant shall be considered to have begun serving such participant's period of obligated service on such course completion date.

"(3) For the purposes of this subsection, the term "course completion date" means the date on which a participant in the Scholarship Program completes such participant's course of training under the program.

"§ 4314. Breach of contract; liability

"(a) A participant in the Scholarship Program (other than a participant described in subsection (b) of this section) who fails to accept payment, or instructs the educational institution in which the participant is enrolled not to accept payment, in whole or in part, of a scholarship under the contract entered into under section 4302(a)(3) of this title, shall, in addition to any period of obligated service or other obligation or liability under the contract, be liable to the United States for the amount of $1,500 as liquidated damages.

"(b) A participant in the Scholarship Program who—

"(1) fails to maintain an acceptable level of academic standing in the educational institution in which the participant is enrolled (such level determined by the educational institution under regulations prescribed by the Administrator),

"(2) is dismissed from such education institution for disciplinary reasons,

"(3) voluntarily terminates the course of training in such educational institution before the completion of such course of training,

"(4) fails to become licensed to practice medicine, osteopathy, dentistry, podiatry, or optometry in a State, fails to become registered as a graduate nurse in a State, or fails to meet any applicable licensure requirement in the case of any other health-care personnel who provide either direct patient-care services or services incident to direct patient-care services, during a period of time determined under regulations prescribed by the Administrator, or

"(5) in the case of a participant who is a part-time student, fails to maintain employment, while enrolled in the course of training being pursued by such participant, as a Veterans' Administration employee permanently assigned to a Veterans' Administration health-care facility,

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to or on behalf of the participant under the contract.

"(c) If a participant in the Scholarship Program breaches the written contract by failing (for any reason) to complete such participant's period of obligated service, the United States shall be entitled to recover from the participant an amount determined in accordance with the following formula:

$$A=3\,\Phi\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover; 'Φ' is the sum of the amounts paid under this subchapter or on behalf of the participant and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States; 't' is the total number of months in the participant's period of obligated service, including any additional period of obligated service in accordance with section 4313(b)(4)(B) of this title; and 's' is the number of months of such period served by the participant in accordance with section 4313 of this title. Any amount of damages which the United States is entitled to recover under this section will, within the one-year period beginning on the date of the breach of the written contract, be paid to the United States,

"SUBCHAPTER III—VETERANS' ADMINISTRATION HEALTH PROFESSIONAL TUITION REIMBURSEMENT PROGRAM

"§ 4321. Eligibility; application; written contract

"(a) To be eligible to participate in the Tuition Reimbursement Program, an individual, in addition to meeting the requirements specified in section 4302 of this title, must—

"(1) be a full-time Veterans' Administration Nursing Service employee permanently assigned to a Veterans' Administration health-care facility who has been employed at such facility for at least two years and be enrolled in a course of training offered by an institution approved by the Administrator leading toward completion of (A) an associate or higher degree in nursing or (B) a masters or doctoral degree in a field related to nursing; or

"(2) if the Administrator determines that it is necessary to assist in providing for the Veterans' Administration an adequate supply of personnel in the health profession concerned, be a full-time Veterans' Administration employee providing either direct patient-care services or services incident to direct patient-care services who is permanently assigned to a Veterans' Administration health-care facility and who has been employed at such facility for at least two years and be enrolled in a course of training offered by such an institution, and approved by the Administrator, leading toward completion of a masters or doctoral degree in an appropriate field.

"(b) In selecting applicants for acceptance in the Tuition Reimbursement Program, the Administrator, in addition to according priorities as set forth in section 4302(c) of this title, shall give priority to the applications of (A) individuals who have demonstrated superior proficiency and performance and who give evidence of sustained and improved performance, as determined by the Chief Nurse of the facility at which the individual is employed, in consultation with the local career development committee, and (B) individuals who have previously received tuition reimbursement under the Tuition Reimbursement Program.

"(c) Before approving tuition reimbursement assistance in any course of training other than nursing, the Administrator, not less than 60 days before awarding such assistance, shall notify the Committees on Veterans' Affairs of the Senate and House of Representatives of the Administrator's intent to award assistance in such course of training and of the reasons why the award of such assistance in such course of training is necessary to assist in providing for the Veterans' Administration an adequate supply of personnel in the health profession concerned.

"(d) The written contract referred to in section 4302(a)(3) of this title between the Administrator and participant in the Tuition Reimbursement Program, in addition to the requirements set forth in such section, shall contain—

"(1) the Administrator's agreement, subject to section 4302(e)(2) of this title, to provide the participant with tuition reimbursement following successful completion (as determined, pursuant to regulations prescribed by the Administrator, by the educational institution involved) of (i) a course or courses required for the course of study described in subsection (a)(1)(B) of this section, or (ii) a course or courses taken as necessary prerequisites for degree program enrollment if a letter regarding the potential enrollment of the participant from an appropriate official of the institution involved includes a statement specifying such prerequisites; and

"(2) subject to section 4302(e)(2) of this title, the participant agrees—

"(A) to maintain employment while enrolld in the course of training being pursued by such participant, as a full-time Veterans' Administration employee permanently assigned to a Veterans' Administration health-care facility; and

"(B) to continue to serve as a full-time employee in the Department of Medicine and Surgery for one year (hereinafter in this subchapter referred to as the 'period of obligated service') after completion of the course for which the participant received tuition reimbursement.

"(e) Tuition reimbursement provided to a participant in the Tuition Reimbursement Program shall not exceed $2,000 per year (adjusted in accordance with section 4302(f) of this title).

"(f) The Administrator may contract with an educational institution pursuant to which such an institution would provide a course or courses at a Veterans' Administration health-care facility to participants in the Tuition Reimbursement Program. Pursuant to the contract, the Administrator may agree to pay to the institution an amount not in excess of an amount determined by multiplying the number of participants in such a course by the amount of tuition reimbursement each participant would receive for enrolling and successfully completing such course.

"§ 4322. Obligated service

"(a) Each participant in the Tuition Reimbursement Program shall provide service in the full-time clinical practice of such participant's profession as a full-time employee of the Veterans' Administration for the period of obligated service provided in the contract of such participant entered under section 4302(a)(3) of this title.

"(b) A participant who on such participant's course completion date is a full-time employee in the Department of Medicine and Surgery shall be considered to have begun serving such participant's period of obligated service on the course completion date.

"(c) Except in the case of a participant whose tuition was paid pursuant to section 4321(f) of this title, if a participant in the Tuition Reimbursement Program fails to successfully complete a course, no reimbursement will be provided and no period of obligated service will be incurred.

"(d) In the case of a participant whose tuition was paid pursuant to section 4321(f) of the title and who fails to complete the course involved, the period of obligation shall be of the same duration as it would have been if the participant had successfully completed the course and the course completion date shall be considered to be the date on which the participant's failure become an established fact.

"(e) For the purposes of this subsection, the term 'course completion date' means the date on which a participant in the Tuition Reimbursement Program completes such participant's course of training under the program.

"§ 4323. Breach of contract; liability

"(a) A participant in the Tuition Reimbursement Program who fails to maintain employment as a Veterans' Administration employee permanently assigned to a Veterans' Administration health-care facility—

"(1) shall not receive reimbursement for tuition for the course or courses in which the participant is enrolled; and

"(2) in lieu of any service obligation arising from completion of a course or courses in a previous semester or quarter, shall be liable to the United States for the amount which has been paid to or on behalf of the participant under the contract.

"(b) If a participant in the Tuition Reimbursement Program breaches the written contract by failing (for any reason) to complete such participant's period of obligated service, the United States shall be entitled to recover from the participant an amount determined in accordance with the following formula:

$$A = 3\,\Phi\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover; 'Φ' is the sum of the amount paid under this subchapter or on behalf of the participant and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States; 't' is the total number of months in the participant's period of obligated service; and 's' is the number of months of such period served by the participant in accordance with section 4322 of this title. Any amount of damages which the United States is entitled to recover under this section will, within the one-year period beginning on the date of the breach of the written contract, be paid to the United States.

"§ 4324. Allocation and distribution of funding

"In determining the amount of funding to allocate to Veterans' Administration health-care facilities in connection with the Tuition Reimbursement Program, the Administrator shall take into account (1) the personnel ceiling for nursing personnel, and (2) the recruitment and retention needs of that facility, as determined by the Administrator.".

SEC. 6. EFFECTIVE DATE; SAVINGS CLAUSE.

(a) The provisions of this Act shall take effect on the date of enactment.

(b) The provision of subchapter IV of chapter 73 as in effect on the date of enactment of this Act shall be deemed to remain in effect with respect to scholarships awarded under such subchapter.

OPENING STATEMENT
SENATOR ALAN CRANSTON
CHAIRMAN
SENATE COMMITTEE ON VETERANS' AFFAIRS

LEGISLATIVE HEARING ON VARIOUS BILLS RELATING TO VETERANS' HEALTH CARE

MAY 21, 1987

Good morning. I am pleased to welcome all of you to this hearing to consider various bills focusing on Veterans' Administration health-care issues. We are very grateful to those of you who are appearing before us today and providing us with your views on these measures. The bills on which we are receiving testimony are: S. 6, S. 105, S. 216, S. 631, S. 731, S. 894, S. 915, S. 939, S. 1062, S. 1063, S. 1065, S. 1089, S. 1125, S. 1136, and S. 1195.

I also express my appreciation to my Committee colleague and very good friend, Senator Dennis DeConcini, for agreeing to take over the chair for the hearing today. Due to other commitments, I deeply regret that I will be unable to join him for the entire morning, but I am confident that the important work of our Committee will be left in very competent hands.

In light of the great need to reduce the towering federal deficit, it is incumbent upon those of us in Congress to exercise prudence and restraint as we consider legislation relating to federal programs of benefits and services. Having said that, however, I want to note what I hope is clear to all here today -- namely, my unswerving commitment to the maintenance of a strong and vital program of benefits and services for those who answered their Nation's call in its hour of need.

I intend to keep this perspective in mind as we move forward with the legislation that is before the Committee today.

The Committee will hear testimony covering a wide variety of subjects -- ranging from proposals related to ways in which the VA might respond to the health-care needs of the veteran population to proposals related to VA Central Office organization. Included are a large number of Administration-requested bills. I pledged last fall that, when I resumed the Chairmanship of the Committee, I would generally introduce Administration bills and list them for committee hearings as appropriate, and I have done that.

As the author of S. 6, introduced on January 6, and S. 1195, introduced on May 12, I will, of course, be very interested in the witnesses' views on those measures, as well as on Senator Murkowski's bills and Senator Mitchell's measure and on the many other bills scheduled for today's hearing.

S. 6: With more specific reference to S. 6, which is cosponsored by Senators Matsunaga, DeConcini, Mitchell, Rockefeller, Graham, Lautenberg, Bingaman, Daschle, and Kerry, I would like, at this point, just to highlight certain of its provisions. This bill has as its basic purpose the continued maintenance and improvement of the VA's ability to meet the health-care needs of our Nation's veterans and their dependents. In view of my very strong concern that we must find methods to reduce the Federal deficit, this legislation seeks to find ways to improve VA programs without incurring significant new costs.

Vietnam-era Veterans Readjustment Counseling Issues: Section 4 of S. 6 contains two provisions relating to the VA's readjustment counseling program for Vietnam-era veterans -- one of which expands the categories of individuals who are entitled to receive counseling, upon their request, through that program and the other of which provides a basis for delaying by one year, from October 1, 1987, to October 1, 1988, the date on which a two-year transition in that program is to begin. The latter provision and a similar one in S. 279 were considered by the Committee at its February 18 and 19 hearings, and a provision derived from those provisions was included in S. 477 as reported by the Committee on March 18, 1987, and passed by the Senate on March 31.

Extension of Readjustment Counseling Eligibility: Under current law, eligibility for readjustment counseling services is limited to veterans of the Vietnam era. Provisions in section 4(a) of S. 6 would make two additional categories of individuals entitled to such services.

First, individuals who served during the Vietnam era but who are still on active duty -- and thus are not "veterans" under the applicable title 38, definition -- would be given entitlement to readjustment counseling. I am not aware of any data suggesting a widespread unmet need for counseling among active-duty personnel who served in Vietnam -- nor am I aware of any study having been made regarding such needs. However, I have received anecdotal reports of some having requested counseling at Vet centers, and I do not believe that any individual who served in the Armed Forces during the Vietnam era and feels a need for readjustment counseling should be barred from eligibility simply because he or she is still on active duty. Section 4(a) of the bill would remove that bar.

The second change in eligibility for readjustment counseling proposed by S. 6 would be to give entitlement to veterans of certain service after May 7, 1975, the end of the Vietnam era. Under this change, the Administrator, after consultation with the Secretary of Defense, would be authorized to specify that service during periods of time in specific locations in which U.S. Armed Forces were under hostile fire would be qualifying service for readjustment counseling purposes. This provision recognizes that members of our Armed Forces are at times exposed to situations short of declared war -- such as existed in Beirut or Grenada, or in connection with our actions against Libya or that possibly exist today in Central America -- that might produce the need for readjustment counseling to help deal with the psychological aftermath of their experiences. We should never allow to go unmet the needs of those who have experienced the stress of combat while serving in the Armed Forces. That is one lesson of Vietnam we surely must have learned.

Pilot Program for Non-institutional Alternatives to Institutional Care: Section 5 of S. 6 would require the VA to conduct, from January 1, 1988, through December 31, 1991, a 4-year pilot program, at not less than five nor more than ten demonstration project sites, to evaluate non-institutional alternatives to institutional care. Through this pilot program, the VA would provide certain veterans with medical, rehabilitative, and other health services and, by contract with non-VA entities, and with health-related services.

These health and health-related services would be provided in non-institutional settings -- such as the veteran's home or a board-and-care home -- with the goal of avoiding institutional care, such as in a hospital, nursing home, or domiciliary facility, for the participants in the program.

Participation would be limited to veterans eligible for and otherwise in need of VA hospital, nursing home, or domiciliary care. Priority for care and services through the pilot program would be accorded to veterans in four categories: Those with service-connected disabilities; those who are 65 or older; those who are totally and permanently disabled; and those who are suffering from Alzheimer's disease or another form of dementia.

Section 5 is, except for date changes and minor drafting changes, identical to section 204 of S. 2422 as reported by our Committee last September. That provision -- which was derived from section 8 of S. 2388, legislation I introduced on April 30, 1986, and from section 3 of S. 2445, as introduced by then-Chairman Murkowski on May 8 -- was considered and passed by the Senate as part of an amendment to H.R. 5299 on September 30, 1986. Unfortunately, we have been unable to gain House agreement on this pilot program thus far, and the provision was not included in the measures that were ultimately enacted in 1985 and 1986 as Public Laws 99-166 and 99-576.

I reintroduced this provision this year because I remain convinced that, in light of current developments in health services which enable more individuals to receive needed care without being institutionalized and of the rapid increase in the number of veterans age 65 and older who may be seeking care from the VA in the years ahead, the VA must take steps to develop new approaches to addressing the health-care needs of veteran patients.

One refinement I intend to propose in this pilot program is based on activities currently on-going in the field. That is to give the VA discretion to carry out the purpose of the program through a case-management-approach activity, without the VA actually providing or paying for certain or all of the services, especially the health-related ones. I hope this will make the provision more acceptable to the Administration and the House Committee.

Services To Overcome Service-Connected Disability Affecting Procreation: Section 2 of S. 6 would authorize the VA to furnish services to help a male or a female veteran or a male veteran's spouse achieve pregnancy in cases in which the veteran's service-connected disability impairs procreative ability.

As a result of my work on behalf of a woman veteran who had a service-connected disability which prevented her from becoming pregnant, I became aware of the fact that the VA does not believe that it has legal authority under current law to provide services to help overcome such a disability. In that case, the veteran was seeking an *in vitro* fertilization procedure. I have also been working for many months with representatives of the Paralyzed Veterans of America who have expressed a strong interest among PVA members in such services for male veterans suffering from spinal cord injuries.

Although I do not believe that the VA's legal interpretation of its existing authority is correct, and did my utmost to bring about a change in that interpretation, I was not successful. Hence, this measure would provide expressly the authority in order to remove any doubts that may exist on this issue.

This provision is derived from section 8 of S. 2388, legislation which I authored last year and our Committee favorably reported in section 205 of S. 2422 and the Senate passed in H.R. 5299. Unfortunately, the House did not agree to this provision and it was not included in the measure that was ultimately enacted as Public Law 99-576.

Increase in Per Diem Payments to State Veterans' Homes: Section 7 of S. 6 would increase the per diem rates paid to State veterans' homes for the care of eligible veterans from $7.30 to $8.70 for domiciliary care, from $17.05 to $20.35 for nursing home care, and from $15.25 to $20.35 for hospital care. These proposed new per diem rates -- which were last increased in April 1984 -- would enable the Federal Government to continue to shoulder an appropriate share of the total cost of providing care to eligible veterans in State Home facilities.

The single most important element of the State Home program is, in my view, nursing home care. The rate increase proposed in S. 6 -- and in S. 216, introduced by my good friend and colleague on the Committee Senator Mitchell -- would restore the VA's share of the average cost of providing such care in State homes to approximately 25 percent, the level that was achieved following the last two increases in per diem rates in 1979 and 1984. The same percentage increase, 19.4 percent, required to increase the rate of nursing home care from $17.05 to $20.35, would be applied to the rate for domiciliary care, thus increasing that rate from $7.30 to $8.70.

The hospital care rate would be increased by 33.4 percent, from $15.25 to $20.35, in order to eliminate the existing disparity between rates for hospital and nursing home care.

We have been working closely with the State Veterans Home organization to try to find a formula that would provide stability to the reimbursement program and also be fiscally prudent. In view of the increased value which the VA has decided to place on the State home program to meet the needs of the radically growing numbers of older veterans, I am giving very serious consideration to recommending such a formula during our Committee's markup of this legislation.

Organization of the Department of Medicine and Surgery: Section 8 of S. 6 would amend section 4103 of title 38, relating to the organization of the Office of the Chief Medical Director (CMD), so as to establish one new position in that office, provide new flexibility in the appointment of individuals to other positions in the CMD's office, and to make various technical changes in the section.

The principal category of changes which would be made by this provision would authorize the Administrator to appoint, in addition to physicians, certain non-physician health-care professionals -- dentists, registered nurses, optometrists, pharmacists, podiatrists, and psychologists -- to various positions in the CMD's office. Thus, these non-physician professionals would be made eligible to serve as Associate Deputy Chief Medical Director (ADCMD). In addition, these professionals -- including dentists, who are already eligible -- could be appointed to the positions of Assistant CMD (ACMD) and Medical Director. Also, in the case of one ADCMD position and not more than two ACMD positions, appointments to such positions of individuals who have served as Directors of VA health-care facilities would also be authorized. These changes in the qualifications of appointees to the office of the CMD would not mandate any change from the current practice. Rather, the intent would be to provide greater flexibility in identifying candidates for the positions in question.

A related change would amend section 4103 so as to specify that all individuals appointed to positions in the Office of the CMD must be qualified in the administration of health services. Under current law, such a requirement is specified as a prerequisite only with reference to non-physicians appointed to not more than two of the ACMD positions.

This section, which Senator Murkowski and I developed together last year, is identical to section 215 of S. 2422 as reported by our Committee last year, which, in turn, was derived in part from S. 2172, legislation introduced last year (and again this year as S. 1125) at the request of the Administration.

Eligibility for Domiciliary Care: Section 3 of S. 6 would authorize the VA to provide domiciliary care to veterans who are in need of such care for the purpose of receiving treatment or rehabilitation and who have a service-connected disability or are incapacitated from earning a living and have no adequate means of support.

Current law provides domiciliary care eligibility for two categories: First, for service-connected-disabled veterans who are suffering from a permanent disability or tuberculosis or a neuropsychiatric ailment and are incapacitated from earning a living and have no adequate means of support and, second, more generally for veterans who are in need of domiciliary care and who are unable to defray the cost of such care. This statutory scheme is both terribly confusing as well as not being consistent with current VA philosophy and practice.

Last year, I introduced, in S. 2388, a revision to the eligibility for domiciliary care and, with the Administration's support, our Committee included that provision in S. 2422 as reported. Unfortunately, we were unable to reach final agreement with our colleagues in the House on this issue and the Senate-passed provision was not included in the legislation enacted as Public Law 99-576. I remain convinced that there is a need for a new statutory eligibility standard for domiciliary care along the lines of this provision. I note that the Administration bill, S. 914, includes a similar provision.

Rules and Regulations Relating to Hospital, Nursing Home, Domiciliary, and Medical Care: Section 6 of S. 6 would amend section 621 of title 38, which relates to the Administrator of Veterans' Affairs' authority to issue rules and regulations relating to the provision of medical care by the VA, so as to eliminate the Administrator's authority to prescribe limitations on the furnishing of such care. This authority in current law dates from the Economy Act of 1933, which was the single most negative legislative action in the area of veterans' affairs in United States' history.

As far as I am aware, the VA, during the over 18 years I have been in the Senate, has not relied on this authority in acting to limit any health-care benefits. However, in 1984, during Congressional action on reconciliation legislation, the VA's Office of General Counsel submitted to the staffs of the two Veterans' Affairs Committees an informal "White Paper" which included a discussion of the availability of this provision in the event that the Administrator desired to provide access to health-care benefits on a different, more restrictive basis than is specifically prescribed in chapter 17 of title 38.

Without reference to whether an Administrator would ever choose to take such an action and without judging whether such an action would be lawful, I can see no basis for vesting in an Executive branch official even the appearance of having such a power to reverse the will of the Congress -- particularly in light of the changes made in VA health-care eligibility by the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, in which Congress mandated the provision of VA care to certain groups of veterans. Therefore, S. 6 proposes that this authority be repealed.

Excessing of VA Properties in Southern California: Section 10 of S. 6 would prohibit the Administrator from taking any action to declare as excess to the needs of the VA, to transfer to another Federal agency, or otherwise to relinquish any VA interest in, any portion of certain lands at two VA medical centers in Southern California -- 46 acres at Sepulveda and 109 acres at West Los Angeles. This provision is substantially identical to a measure -- S. 2141 -- which I introduced in the last Congress, together with Senators Matsunaga, DeConcini, Mitchell and Rockefeller, to address the Administration's very ill-advised proposal to excess those parcels of land. Although I worked very hard on this issue in the last Congress, I was successful in achieving only a temporary solution to the problem. While this provided a much-welcomed breathing period -- until July 1, 1988 -- for California's veterans, Los Angeles commuters, and West Los Angeles and Sepulveda neighbors and children, it failed to provide a permanent and totally satisfactory solution. The provisions of this measure would constitute a permanent solution.

Let me review the arguments against the Administration's proposal to sell-off the VA land. First, these parcels provide important buffer zones between the facilities and the surrounding communities. I strongly believe that not all lands should be developed; open space is a valuable commodity, especially in highly congested areas such as West Los Angeles.

Second, some of these lands will be necessary to provide latitude for possible expansion of services for veterans in the future. Possible uses mentioned in a 1986 VA task force report could include a planned new State veterans' home, veterans' recreation, and joint venture projects with UCLA or others. Active exploratory efforts are underway with respect to the first and third uses.

Third, a major portion of the land in question at West Los Angeles is either part of a deep ravine or separated from the facility by the ravine. Without massive landfill, this land is unattractive and difficult to utilize and would not have the commercial value that the Office of Management and Budget has attributed to it.

Fourth, the VA has used the ravine for waste disposal, including remnants of an old VA hospital that once stood on an adjacent site. This would compound problems for any developer since the contaminated soil would need to be removed and the substructure of the land shored up before landfilling is begun. Additionally, the parcel includes an area where the VA once disposed of radioactive waste, and digging in the area could be hazardous.

Fifth, conditions exist that suppress the market value of the property, including in the case of West Los Angeles, a county moratorium on new "access cuts" into Wilshire Boulevard. Also, the zoning for the VA land is "open space", and no development could be undertaken without a zoning variance -- which is highly unlikely given the strong opposition to the Administration's proposal by both the county board of supervisors and Los Angeles City officials.

Sixth, the major veterans organizations -- both nationally and in the State -- have expressed and continue to express vigorous opposition to any excessing of this land.

Seventh, the surrounding communities in both West Los Angeles and Sepulveda strongly oppose the additional major construction activity and the resultant development and traffic congestion that would occur, as well as the disruption of a number of existing leases and agreements with the VA regarding the use of some of the land proposed.

In short, I have not been able to identify any significant gain to be achieved by supporting the excessing of these properties beyond it resulting, at some distant point in time, in revenues to the Federal Government -- and probably a much smaller amount of revenues than OMB projects.

Report on Certain Activities of Medical and Other Health-Professional Schools Affiliated with the VA: Section 10 of S. 6 would require the Administrator to submit a report to the two Veterans' Affairs Committees, providing detailed information with regard to efforts to motivate VA affiliated institutions to increase their efforts in the areas of research and training in the care of older patients.

It is abundantly clear that a major public policy issue currently facing our Nation is how we will respond to the needs of our elderly citizens as the population ages. It has been estimated by the Census Bureau that by the year 2030, the proportion of the U.S. population age 65 and older will have risen to nearly 22 percent from the current level of approximately 12 percent. This fundamental shift in the composition of our society has significant implications for how national resources are to be allocated and how a wide range of services are to be furnished.

Because veterans of military service cluster in age groups related to the periods of major conflicts -- World War I, World War II, the Korean conflict, and the Vietnam era in this century -- trends relating to the general population are manifested differently in the veteran population. In the area of aging, the dramatic rise in the proportion of elderly persons in the overall population, which will peak around the first third of the next century, will be accelerated in the case of veterans. The veterans of World War II, who make up 37 percent of the total veteran population, are already approaching an average age of 65, and the veterans of the Korean conflict are just behind them. In 1985, the veteran population age 65 and over reached 4.8 million, and by 1990 it is estimated that 7.2 million, more than 60 percent of the male population 65 and over, will be veterans. By the year 2000, veterans over 65 will number almost 9 million and make up 37 percent of the veteran population.

Because of the large numbers of veterans who are entering the age range with the greatest need for health and health-related services, the VA, spurred on by congressional interest, has been very active for a number of years in seeking ways to meet the needs of older veterans. Despite the many activities in which the VA is involved, I am concerned that the agency may not be taking full advantage of the potential influence that it has to motivate health-care training institutions which are affiliated with the VA.

S. 1195: On May 12, I, together with Senators Murkowski, Matsunaga, DeConcini, Mitchell, and Rockefeller, introduced S. 1195 to help the VA overcome difficulties in the recruitment and retention of nurses, pharmacists, occupational and physical therapists, and other health-care personnel. S. 1195 is now also cosponsored by Senator Simpson.

A cadre of qualified health-care personnel is the backbone of a strong VA health-care system. Dedicated nurses, in particular, provide the essential day-to-day care and treatment to veteran-patients. It is critical that the VA be able to attract and retain such personnel. We need to ensure that the VA is able to compete effectively with non-VA health-care employers for the services of qualified health personnel. Without sufficient qualified personnel, DM&S cannot be expected to fulfill its mission of providing high-quality health services to eligible veterans.

Title 5/Title 38 Personnel Hybrid Expansion: First, section 2 would move the positions of pharmacists and occupational therapists, in which VA medical centers are reporting shortages, into the title 38/title 5 "hybrid" category. The hybrid was created in Public Law 98-160 in order to address the need to improve the VA's ability to attract and retain certain health-care personnel -- namely, registered respiratory therapists, licensed practical or vocational nurses, and physical therapists -- as to which the VA was then experiencing significant shortages. Although those health-care personnel remain under the title 5 personnel system, the Administrator has the flexibility provided under the title 38 personnel system with regard to hiring practices and setting pay rates, thereby enabling the VA to respond more quickly and more effectively to these shortages and to target those efforts to the facilities most in need. These "hybrid" employees would continue to have their personnel protections provided under title 5 only.

Adding Physical Therapists to the Health Professional Scholarship Program: Second, S. 1195 would open the Health Professional Scholarship Program to physical therapists and other individuals who provide direct patient-care services or services incident to direct patient-care services. Presently only health-care providers under the title 38 personnel system are eligible for the Scholarship Program.

Because the education and training needs have been the greatest for nurses, thus far the scholarships have been used exclusively to help train nurses. The VA indicated in its fiscal year 1988 budget request that it would like to provide scholarship support to physical therapy (PT) students -- PTs have the highest vacancy and turnover rates of any health profession in the VA -- as well as nurses. Since PTs are under the title 38/title 5 hybrid system, they are currently not eligible. Our legislation would enable the VA to make those awards.

Third, the period of obligated service under the Scholarship Program would be lengthened from one year for every year of support to two years for every year of support, in order to encourage greater retention of nurses and other professionals who receive educational assistance under the Program. S. 1195 would also provide that priority in awarding scholarships for nurses would be given to nurses in their fourth year of training so that they would be able to begin employment with the VA as soon as possible.

Nurse Recruitment and Retention: Fourth, section 3 of S. 1195 would provide nurses who work on Saturdays with the same premium pay currently applicable to Sunday work. This modification would allow the VA to be more competitive with the private sector, where many medical facilities offer weekend premium pay, in attracting and retaining nurses.

Fifth, S. 1195 would establish a tuition reimbursement program for full-time nursing personnel -- or, when needed, for other full-time health-care personnel -- for academic courses leading toward completion of any degree program in nursing or in a field related to nursing, or in other appropriate degree-granting fields for other personnel. Over 80 percent of non-VA hospitals offer tuition assistance as a benefit for full-time employees, which also places the VA at a competitive disadvantage. Under this new program, nurses who have worked a minimum of two years and who are performing in a superior fashion would be eligible to receive a maximum of $2,000 a year in tuition assistance. They would be required to work for the VA for a period of 1 year following completion of the last course taken.

Sixth, section 4 of S. 1195 would require that Chief Nurses or their designees at VA health-care facilities be members of those facilities' policy-making and fiscal committees in order to give nurses greater input into the decision-making process regarding policies that affect them and the overall management of VA facilities.

S. 216: Introduced by Committee Member George Mitchell, myself, and Senators Matsunaga, Boren, and Nickles, S. 216 is, as I noted earlier, substantively identical to the proposed legislation in section 7 of S. 6.

S. 631, S. 713, S. 894: Introduced by the Ranking Minority Member of the Committee, Senator Murkowski, S. 631 would require standardization of VA procurement for medical and pharmaceutical supplies in order to achieve substantial cost-savings; would authorize payment of bonuses to nurses working in selected VA medical facilities; and would authorize the Administrator to furnish certain hospital services to veterans not living in the U. S..

Administration Bills: Those bills which were introduced at the request of the Administration and upon which we will receive testimony can be grouped into four categories. S. 915, S. 1062, S. 1065, S. 1125, and S. 1136 relate to personnel issues -- licensure, employee performance reviews for probationary employees, payment of on-call pay, removal of personnel in executive positions, and disciplinary actions taken against non-probationary employees, respectively. S. 939 addresses benefits for veterans in community nursing homes, S. 1089 clarifies issues regarding the prioritizing of State Home Grants, and S. 1063 changes regulations referring to tort claims and hospital cost collections.

There are several additional legislative initiatives that I want to announce and outline this morning. They will be forthcoming over the next few weeks and will be considered at our markup on July 16.

Beneficiary Travel: First, regarding beneficiary travel, over the past several weeks, there has been much discussion about the revised regulations which became effective on April 13, 1987. I share the concern of those who believe that some veterans may effectively be denied access to medical care as a result of their being unable to afford transportation to a VA facility. I know that this was a major focus of our extensive oversight hearings in Hawaii on April 14, and Senator Matsunaga has expressed great interest in rectifying the inequitable effect of the new regulations in his State. Other Committee members share similar concerns. Thus, Ranking Minority Member Frank Murkowski and I have directed our staffs to work together to explore alternatives to the Administration's cutback and present the Committee with a bipartisan proposal for consideration when we mark up health legislation in July.

Vet Center Transition: Second, regarding the Vet Centers and their transition now mandated by law, of course, S. 477 has been passed by the Senate to postpone the beginning of that transition for a year. I hope that legislation will move through the House in the next month or so. But that will not be sufficient in my view given the clear hostility to the program which this Administration has continually manifested. The extraordinarily hasty and haphazard decisions made in January to relocate 9 Vet Centers beginning on July 1 -- one in Wilmington has already been moved -- is the latest manifestation of this animus.

My view is that careful, case-by-case, periodic decisions should be made as to whether the purposes of the readjustment counseling program and the mission of the VA can best be served by maintaining a Vet Center's community-based location or moving it to a medical facility. There should be no fixed formula requiring such relocations on a wholesale basis, as under present law. I am certain that the current law transition requirement will lead to arbitrary decisions and to poor public policy results.

Despite our success last year in making the transition period a gradual, 2-year process, the end result under current law is still that more than half of the Vet Centers must be moved or closed. There is no one who knows whether that result makes good policy sense in general. Based on the information presently available, including a 5.4-percent increase in new clients and an 8.8-percent increase in visits at Vet Centers for the first 6 months of FY 1987 as compared to a year ago, I have concluded that the policy reflected in current law is seriously flawed.

Hence, I will shortly be introducing legislation to try to ensure that future decisions regarding the readjustment counseling program and the Vet Centers are made carefully on a case-by-case basis -- not with a meat axe. This legislation would accomplish a number of objectives, including --

1) eliminating the statutory requirement for a fixed transition of Vet Centers from their community locations to VA medical facilities;

2) replacing that provision with one permitting such relocation only upon determinations by the Chief Medical Director that certain criteria, relating to ensuring the continued availability and effective provision of readjustment counseling services, have been met;

3) requiring that 60 days' advance notification and detailed information (as currently required by section 210(b)(2) of title 38) be submitted to the Veterans' Affairs Committees before any such relocations are made;

4) prohibiting the relocation of Vet Centers, or any other Readjustment Counseling Service reorganization, in any fiscal year involving 25 or more RCS personnel except in accordance with the

The VA is an important component in our war against AIDS. It will treat thousands of AIDS patients, conduct state-of-the-art basic and clinical research, and provide important prevention services. To do that effectively, it must be equipped with the resources it needs to perform these vital life-saving and life-prolonging activities.

Construction: Finally, I welcome the views in the written statements of today's witnesses regarding the Administration's FY 1988 budget request of $400 million for major construction projects. We particularly seek your opinions on the Administration's proposal for no FY 1988 funding for new VA nursing-homes. When our Committee, on February 27, 1987, reported its views on the FY 1988 budget to the Committee on the Budget, we recommended an FY 1988 major projects appropriation of $420 million, or $20 million more than the Administration requested, to include funds for up to four new VA nursing-homes or other priority projects.

Conclusion

There are obviously a great number of issues to be discussed today, all of which, if enacted into law, will greatly affect the care of our nation's veterans. The members of our Committee are very interested in the ideas and views of those appearing before us today as well as those who have submitted written testimony. I again want to thank the witnesses for their participation and help on these important matters.

existing reorganization requirements set forth in section 210 of title 38, thereby allowing such large Readjustment Counseling Service reorganizations to proceed only for a fiscal year if proposed at the time of the President's budget submission -- 8 months earlier -- for that year;

5) protecting the budget and FTEE ceiling for any Vet Center relocated to a VA medical facility;

6) making all war veterans eligible for, although not entitled to, readjustment counseling services (in addition to the entitlement changes proposed in S. 6);

7) explicitly authorizing the relocation at Vet Centers of appropriate DVB and DM&S services; and

8) requiring that all Vet Center personnel who have served effectively for a substantial period of time be converted to career positions.

I look forward to working with Senator Murkowski and all of our Committee members to develop bipartisan legislation on the beneficiary travel and Vet Center issues.

Quality Assurance: I also want to note that yesterday I joined Senator Murkowski in releasing a GAO report on one key element to the VA's quality assurance effort, the patient injury reporting program. Senator Murkowski and I pledged to take whatever action is necessary, including developing legislation or proceeding with oversight hearings if needed, in order to correct the serious problems identified by GAO. I look forward to working with him and the other members of the Committee on this issue which requires immediate remedial action by the VA.

AIDS: Another issue we are focusing on at this hearing, AIDS, is perhaps the most serious public health issue that our nation, and indeed the world, is confronting. Although the disease was unknown less than 10 years ago, AIDS is rapidly becoming the modern-day plague -- claiming thousands of lives monthly. We have already lost more than 20,000 Americans. More than one and a half million Americans are infected with this insidious virus -- a majority of whom will likely eventually develop the disease. The count worldwide is equally alarming -- between 5 and 10 million people may be carrying the AIDS virus. Every year I have fought vigorously for more money to combat this catastrophe-in-the-making. The budget for AIDS has increased 10 times over the last 4 years -- but it's still not enough. It will not be enough until we've put an end to the pain and the suffering and the dying.

About 6 percent of all cases in the U.S. are being cared for by the VA. The VA has treated more than 2,00 people with AIDS since 1981 and will see about 1,300 this year alone. If the AIDS caseload continues at the same rate, the VA may see 14,000 patients by 1991. AIDS is a very expensive disease to treat because of the numerous physical, neurological, and psychological problems associated with it and the high cost of the only experimental drug, AZT, approved by the FDA for AIDS treatment.

In order to ensure that the VA has sufficient resources to care for the growing number of veteran-patients with AIDS, I proposed, and the Committee unanimously agreed earlier this year, to recommend $47.5 million in additional funding for VA medical centers that provide care to the most AIDS patients. Although this increase is not expressly assumed in the budget as passed by the Senate, I believe that there will be room in the budget and in the allocation to the HUD-Independent Agencies Appropriations Subcommittee for this purpose.

We are also pursuing questions -- including through an intensive GAO study -- of how to modify the VA's Resource Allocation Methodology, which relies on a D.R.G.-based system, so that it will adequately recognize the total expense associated with AIDS for purposes of reimbursing those VA facilities which have a significant AIDS caseload. Finally, I believe it is essential that VA medical centers provide education, counseling, and other prevention activities for both health-care workers and patients and will be pursuing those issues with the VA. For instance, the VA's many drug abuse treatment programs would be ideal settings to do counseling and education for those individuals who are at particular risk for AIDS.

OPENING STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK) REGARDING THE COMMITTEE'S MAY 21, 1987 HEARING ON VA HEALTH-CARE

Welcome to this morning's hearing of the Committee on Veterans' Affairs. I commend my friend from California, Senator Cranston, for holding this hearing to discuss the full range of issues relating to veterans' health care.

I welcome Dr. John Gronvall, the VA's Chief Medical Director, the veterans' service organizations, and other witnesses present today.

Our agenda this morning is very full and a multitude of measures will be considered. I could discuss each legislative proposal -- some of which are measures I introduced and feel strongly about -- but in the interest of time -- I'll make my remarks brief.

Nursing Shortage

As I have discussed on numerous occasions, I am extremely concerned about the VA's ability to recruit and retain quality health-care professionals. Thus, I introduced S. 713, a bill which would provide for a bonus of up to $20,000 for registered nurses who agree to work full-time in a specialty area or geographic region for at least three years. Let me be clear

THAT THIS BILL IS INTENDED TO BE BOTH A RECRUITMENT AND, EQUALLY IMPORTANT, A RETENTION TOOL -- TO PROVIDE THE VA WITH GREATER FLEXIBILITY IN RETAINING SKILLED AND EXPERIENCED NURSES IN THE VA SYSTEM. I WAS ALSO PLEASED TO JOIN WITH SENATOR CRANSTON IN INTRODUCING S. 1195, A BILL WHICH WOULD ADDRESS NOT ONLY THE NURSING CRISIS BUT DIFFICULTIES IN RECRUITING AND RETAINING OCCUPATIONAL THERAPISTS AND PHARMACISTS AS WELL.

Procurement Reform

In times of limited fiscal resources, it is vital that the VA make every effort to purchase medical and pharmaceutical supplies in the most cost-effective manner possible. The VA no longer has the luxury to do otherwise. The question is simple. Will the VA spend its money to provide patient care or, as Coopers and Lybrand stated in their report released last year, purchase medical supplies locally where the prices are generally 25 to 50 percent higher than through the VA Depots? All too often, the VA purchases items on the open market as one-time, nonpreferred customers -- that is, from a drug store at the same price that you and I pay. It is unbelievable that a medical-care system the size of the VA which purchases nearly $1.2 billion in supplies and drugs does not receive the most favorable prices; but, according to the study commissioned by the VA, it simply does not.

Coopers and Lybrand made recommendations to the procurement program. I closely reviewed that study and introduced a bill which I believe would make needed improvements. Today's testimony indicates that the VA does not want the Congress to legislate in this area and would prefer an administrative approach. However, since the release of the report almost one year ago, to my knowledge, not one system-wide program initiative to reduce procurement costs has been implemented. And yet, we paid close to a million dollars for the study.

Beneficiary Travel

I am also very concerned about the VA's beneficiary travel program. In the past, I have supported initiatives to control the cost of that program. I recall that about $100 million, in addition to staff costs at each medical center, was being spent annually to provide that benefit.

The VA has begun to implement new regulations whereby only in certain very limited cases would travel be reimbursed. These new guidelines place significant hardship on certain veterans who cannot afford to pay for their travel or must travel great distances in order to receive needed health-care services. This issue is particularly troubling in my State of Alaska -- which is one-fifth the size of the U.S. and has less roads than the State of Massachusetts. Travel is obviously

DIFFICULT. UNFORTUNATELY, THE REGULATIONS ARE NOT BEING INTERPRETED TO ALLOW FLEXIBILITY IN FUNDING BENEFICIARY TRAVEL. I INTEND TO SEEK CHANGES TO THE REGULATIONS.

PRIVATE SECTOR VS. VETERANS' ADMINISTRATION

I AM ESPECIALLY TROUBLED BY SOME OF THE TESTIMONY WHICH I HAVE REVIEWED THAT IS EXTREMELY CRITICAL OF THE PRIVATE SECTOR. I AM PROUD OF THE POSITIVE ROLE THAT THE PRIVATE SECTOR PLAYS IN PROVIDING HEALTH CARE TO VETERANS IN ALASKA AND THROUGHOUT THIS NATION. I DO NOT SUBSCRIBE TO THE THEORY THAT VETERANS WHO RUN OR WORK IN MANY OF OUR NATIONS'S LARGEST CORPORATIONS AND SMALLEST BUSINESSES ARE INSENSITIVE OR INCAPABLE OF SERVING VETERANS. THIS "US-AGAINST-THEM" ATTITUDE SERVES NO USEFUL PURPOSE. IT SEEMS TO ME THAT THE ISSUE -- ESPECIALLY WITH REGARD TO THE VA'S HOSPITAL COMPUTER INFORMATION SYSTEMS -- IS NO LONGER PRODUCTIVE WHEN THE DISCUSSION CEASES TO FOCUS ON THE BEST INFORMATION SYSTEM TO MEET THE VA NEEDS. THIS IS UNFORTUNATE. I HAVE ALWAYS BEEN A STRONG SUPPORTER OF AUTOMATION AND BELIEVE IT'S LONG OVERDUE IN THE VA MEDICAL CARE SYSTEM. THE QUESTION RELATES TO THE BEST MEANS TO ACHIEVE THAT END. I INTEND TO ADDRESS THIS ISSUE OF DHCP VERSES IHS LATER THIS MORNING DURING THE SENATE'S CONSIDERATION OF THE FISCAL YEAR 1987 SUPPLEMENTAL APPROPRIATIONS BILL.

GAO REPORT

As many of you already know, the General Accounting Office has just completed a report on a component of the VA's quality assurance program known as Patient Injury Control. This report contained some very damaging information and statistics about this program.

I am deeply concerned about the results of this report, and I intend to work closely with the Chairman to correct the deficiencies in this program. If veterans are to maintain confidence in the VA health-care system, it is vital that the VA have an EFFECTIVE quality assurance program. These problems must be corrected immediately.

Again, I look forward to hearing the testimony this morning and to working with my colleagues on these important measures.

Thank you, Mr. Chairman.

STATEMENT
SENATOR GEORGE J. MITCHELL
COMMITTEE ON VETERANS' AFFAIRS
MAY 21, 1987

Good morning, Mr. Chairman. I am pleased to join you in welcoming the witnesses to our hearing to consider various bills focusing on Veterans' Administration health-care issues.

I am very interested in their views on all of the many bills scheduled for today's hearing. Because of other commitments, however, I will be unable to stay for the entire hearing. I will carefully review the testimony given by all witnesses.

The Committee will hear testimony covering a wide variety of subjects and legislation, several of which I have cosponsored: S. S. 6, the "Veterans' Health Care Improvement Act of 1987" and S. 1195, the "Veterans' Administration Health-Care Personnel Act of 1987," both of which were introduced by the Chairman.

They will also discuss S. 216, legislation I introduced in January, which would require the VA to pay a higher percentage of the total cost of providing care to eligible veterans in state veterans homes by increasing the per diem payments made by the VA directly to eligible state veteran homes.

If enacted, the VA's share of average cost of providing care in state homes will be approximately 25 percent, the level that was achieved following the last two increases in per diem rates.

This proposed new per diem rate increase, which would be the first increase in almost three years, would enable the Federal government to continue to shoulder an appropriate share of the total cost of caring for veterans in State homes.

I'd like to briefly comment on one of the other legislative initiatives not on today's schedule that the Chairman discussed in his opening statement, regarding beneficiary travel.

Over the past several weeks, there has been a great deal of dicussion among Maine's veterans about the revised regulations which became effective on April 13, 1987.

I want to re-inforce my interest in this issue, Mr. Chairman.

I share the concern of the many Maine veterans who have raised this subject with me directly that some veterans may effectively be denied access to medical care as a result of their being unable to afford transportation to a VA facility.

I was very pleased to hear from the Chairman that he and our distinguished Ranking Minority Member, Frank Murkowski, have directed the committee staff to develop a bipartisan alternative to the Adminstration's cut-back and present that proposal for inclusion in the health legislation in the near future.

The present situation is unacceptable to me. I am very eager to work with the Committee's leadership in exploring an equitable solution to the present problem.

There are a number of issues to be discussed today, so I do not want to take up more of the Committee's time.

I again want to thank the witnesses for their participation in this morning's hearing. I look forward to working with Senator Cranston, Senator Murkowski, and the other members of the Committee in the comming weeks on all of the issues raised here this morning.

STATEMENT OF SENATOR DENNIS DeCONCINI
BEFORE THE VETERANS' AFFAIRS COMMITTEE HEARING ON VETERANS' HEALTH CARE IMPROVEMENTS AND FACILITIES CONSTRUCTION
MAY 21, 1987

Thank you, Mr. Chairman, for your strong leadership in this most critical aspect of Veterans' affairs--the Veterans' Administration health care system. Your sponsorship of many of the bills of our agenda today is the best evidence of that leadership. I am pleased to have the opportunity to be an original cosponsor on all of your bills to improve the quality of medical care received by these devoted Americans who have borne the battle to preserve the many freedoms we continue to enjoy.

Many of the proposals we have before us today mark the beginning point for making some fundamental improvements in the VA medical care system. The extension of eligibility to certain veterans for readjustment counseling, authorization for a pilot program for noninstitutional care for others, a revitalized emphasis on the needs of the aging veteran, and the recruitment and retention of quality health care professionals are issues which require our immediate action. I look forward to hearing your testimony. I know it will be helpful to the Committee in its deliberations on how to proceed with these various legislative initiatives. I want to particularly thank the Committee staff for their hard work preparing for today's hearing.

Before we continue with the testimony, I would like to add that it is indeed appropriate that this Committee is addressing the problem of recruitment of highly qualified nurses in the same month in which the Veterans' Administration is honoring the 34,000 competent, dedicated, and compassionate professionals who are VA nurses. Last year these valued professionals cared for nearly 20 million patients on a 24-hour basis. Recognition alone, however, has not been effective in the recruitment and retention of these health care professionals.

I know from reports from the VA medical centers in my home state of Arizona that these hospitals are having a very difficult time finding and retaining nurses in many specialized areas, and the problem is getting worse. Entire wards have been closed for extended periods because of the nursing shortage. I strongly agree with the distinguished Chairman that this Committee cannot avoid action simply because we find it difficult in light of the nation's budget deficit. My distinguished colleagues on this Committee and the Senate at large must remember that the quality of care our veterans receive is at stake. We must be innovative and aggressive to insure that the VA has the tools to compete within this highly competitive market for nurses and other health care professionals.

I believe the bills which we are considering today to improve VA nurse recruitment and retention can make a significant contribution to that end.

I thank you all again for your interest in today's proceedings. Let us continue with the testimony.

STATEMENT OF

JOHN A. GRONVALL

CHIEF MEDICAL DIRECTOR

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. SENATE

May 21, 1987

Mr. Chairman, we welcome the opportunity to appear today to testify on the many important measures on your legislative agenda. The objectives inherent in these proposals--to improve VA health care and health-care administration, to assure that VA has the tools to recruit and retain needed health-care personnel, to provide for needed VA medical construction, and to maintain a strong State veterans home program--are objectives we share. We are pleased to be able to offer our perspectives on these vital subjects. We also appreciate your introducing so many of the legislative proposals we have submitted and your inclusion of these bills in this important hearing.

S. 6 - VETERANS' HEALTH CARE IMPROVEMENT ACT OF 1987

I wish to begin by discussing your bill, S. 6, entitled the "Veterans' Health Care Improvement Act of 1987." While VA supports enactment of several provisions of S. 6, we do not support the bill in its entirety.

Section 2 of the bill would authorize VA to furnish services to achieve pregnancy in a veteran, or a veteran's spouse, if necessary to overcome a service-connected disability which impairs the veteran's procreative ability. Thus, if a woman veteran is unable to become pregnant due to damaged Fallopian tubes resulting from a service-connected disability, the VA could furnish, or pay for artificial insemination or in-vitro fertilization services for the woman. Similarly, VA could furnish such services to a woman whose spouse is unable to impregnate her due to a service-connected disability. We oppose this provision for the following reasons.

There are certainly compelling cases of veterans with service-connected disabilities which impair their ability to procreate. Advances in medical technology and technique have begun to make it possible for medical science to help some affected couples. Nevertheless, philosophical and practical questions continue to exist regarding the appropriateness of VA authorizing services to assist in a veteran or a veteran's spouse in becoming pregnant. Furthermore, the Office of Technology Assessment (OTA) is continuing a detailed study of this entire subject, a project begun last summer. Until the OTA study is completed and more of the vexing questions regarding this subject have been answered, we do not believe this authority should be enacted. We estimate that the costs of section 2 would be $.58 million in the first fiscal year and $4.1 million over five fiscal years.

Section 3 of the bill would amend title 38 to change and clarify the eligibility criteria for domiciliary care. It would provide that to be eligible for domiciliary care, a veteran must need such care and be either (1) service-connected, or (2) incapacitated from earning a living and have no adequate means of support. We support enactment of this provision.

Under existing domiciliary care eligibility provisions, the law appears to impose more stringent requirements on the service-connected veteran than on other veterans. Thus, to be eligible for domiciliary care, the service-connected veteran must have a permanent disability, tuberculosis, or a neuropsychiatric ailment; be incapacitated from earning a living; and have no adequate means of support. In contrast, statutory provisions governing domiciliary eligibility for other veterans impose none of these requirements, and condition eligibility on an "inability to defray" and a need for such care. Section 3 would rectify this inequity, making domiciliary care eligibility requirements the same for all veterans. In favoring enactment of this proposal, VA does not intend to place the nonservice-connected veteran on an entirely equal footing with the service-connected veteran. If the proposal were enacted, VA would propose implementing regulations that would give the service-connected veteran priority over the nonservice-connected veteran. We would also anticipate that implementing regulations would continue in effect the regulatory income limits ($415/month) which now establish that a veteran has "no adequate means of support." We are, however, reexamining whether that precise dollar limit needs revision. We estimate that enactment of section 3 would not impose additional costs. Such enactment would, however, carry out the purposes of a similar VA proposal contained in S. 914.

Section 4(a) of the bill would authorize VA to provide readjustment counseling to (1) persons still on active duty with the Armed Services who served during the Vietnam era, and (2) those who served in the Armed Services after the Vietnam era in combat situations. We believe our readjustment counseling program has been an effective one, and one which could benefit active duty personnel who served in Vietnam as well as in combat areas such as Grenada and Lebanon. VA already has authority to provide these services to active duty personnel under Public Law 97-174, the authority for VA to share resources with the Department of Defense. Further, the

Department of Defense has responsibility to provide such care to active duty personnel under that authority. Accordingly, we oppose this aspect of the proposal. We would support, however, the amendment to section 612A to extend eligibility for such services to those veterans who served on active duty during a period after May 7, 1975, in an area in which hostilities occurred. We estimate that the costs of enacting section 4(a) would not be significant in magnitude.

Section 5 of the bill would require VA to conduct a 4-year pilot program at not less than five nor more than ten geographic sites, through which participating veterans would receive appropriate health and health-related services. VA would be required to furnish appropriate "health-related" services solely by contract with appropriate public and private agencies, as well as to provide "case management" services (as defined) to each participant. The measure sets additional requirements as to the program's design, and requires VA to evaluate the effectiveness of providing alternative modes of care, as well as to assess the impact of that effort.

VA favors the basic concept of developing alternatives to institutional care. Accordingly, we have operated programs such as adult day health care and hospital-based home care as alternatives to institutional care. We are also implementing the authority, granted by Public Law 99-576, to furnish respite care to veterans, and we have begun planning to implement new authority to furnish "home health services" to a wider array of veterans, and to furnish services to chronically mentally ill veterans in noninstitutional settings. We do not favor the particular program proposed in section 5, however.

First, we object to the requirement that such a program include provision of "health related services." Since VA's authority to provide "medical services" is a broad one, this provision would appear to require the Agency to furnish services that cannot be furnished under existing law, such as homemaker or chore services, for example. As we have stated in the past, the principal statutory mission of the Department of Medicine and Surgery is to provide a complete medical and hospital service to eligible veterans. That mandate contemplates that VA will provide veterans with all needed medical services, either in VA-operated facilities, or in limited circumstances when necessary, in facilities for which the VA contracts. Furnishing homemaker and chore services, for example, is a departure from that role, and duplicates, in large measure, the assistance for which the basic aid and attendance allowances are currently paid to many veterans. It would also duplicate the availability of such services which are often available from community resources. We oppose departing from the longstanding public policy that the Department of Medicine and

Surgery be responsible for medical services for veterans, while other needs be met through other benefit programs or resources in the community. We also object to this provision because it is unduly prescriptive. We see no need for Congress to mandate the design of such an effort, such as in setting in law specific numbers of geographic areas, the use of specific numbers of VA geriatric evaluation units, and the degree to which VA must contract for services. In many respects, the requirements of the measure are so specific that they deprive VA of the latitude needed to derive real benefits from any such pilot program. We estimate the costs of section 5 to be $9.2 million in the first fiscal year and $36.9 million over four fiscal years.

Section 6 of the bill would amend section 621 of title 38, which directs the Administrator to promulgate rules and regulations which are necessary and appropriate for the efficient provision of VA health care. The statute refers only to hospital, nursing home, and domiciliary care, all inpatient care programs, but does not refer to medical services, which include outpatient care. We agree that it is appropriate to add references to "medical services," as this provision does, making the section applicable to care furnished on an outpatient basis. We see no reason, however, to delete the long-standing provision currently set forth in section 621(2), and we oppose that aspect of the provision. We estimate that enactment of section 6 would not impose additional costs.

Section 7 of the bill as well as S. 216, introduced by Senator Mitchell, would amend section 641 of title 38, United States Code, to increase the per diem rates VA would pay to States for the care of veterans in State homes. The amount payable for the domiciliary level of care would increase from $7.30 to $8.70, and a single rate of $20.35 would be payable for both hospital and nursing home care, up from $15.25 and $17.05 respectively. We oppose this provision because such an increase is not necessary in Fiscal Year 1988.

VA is required by section 641(c) of title 38, United States Code, to report to the Congress every three years regarding the adequacy of State home per diem rates. The first and most recent report was submitted to Congress last fall. It stated that there are factors suggesting that per diem rates are adequate and others suggesting that increasing rates may be appropriate. For example, it was stated that the current per diem rate does not appear to inhibit State home construction activity on the part of states. On the other hand, maintenance of the VA's percentage share of the cost of operating State homes over the next few years may require a per diem rate increase. The report concluded that some increase in per diem rates over the next five years may be appropriate. While an increase may be needed in the future, VA does not believe such an increase is necessary for Fiscal Year 1988. We estimate that the costs of section 7 would be $14.5 million in the first fiscal year and $77.3 million over five fiscal years.

Section 8 of the bill would amend section 4103 of title 38, United States Code, to add flexibility in staffing the office of the Chief Medical Director (CMD). The provision would increase to two the number of authorized Associate Deputy Chief Medical Directors (ADCMD), and permit one of those positions to be filled by a nonphysician qualified in one of six specified health care professions, or who is a Director, or qualified to be a Director, of a VA health-care facility. The provision would also permit Directors of VA health-care facilities, or persons qualified for that position, to be appointed to as many as two of the eight authorized Assistant Chief Medical Director (ACMD) positions. Finally, it would require that all individuals appointed to positions in the Office of the Chief Medical Director be qualified in the administration of health services.

VA supports legislation to give the Agency greater flexibility in staffing the office of the Chief Medical Director, but we suggest an alternative to section 8 of this bill. That alternative is contained in S. 1125, a bill which VA recently submitted to Congress. We believe that S. 1125, because it gives greater flexibility, would be a better refinement of section 4103 than that provided by this bill.

The Administration bill (S. 1125), like S. 6, would authorize a second Associate Deputy CMD position, and would broaden the categories of individuals who could serve in either of the two positions to include highly qualified nonphysicians with health-care management and hospital management backgrounds and skills. The number of authorized Assistant CMD's would be reduced from eight to seven, partly because of the addition of the second Associate Deputy CMD position. The Administration bill would also make discretionary much of the rigid structure now set forth in section 4103 by eliminating the requirement that specific Service Directors exist in the Office of Chief Medical Director. All of the changes in S. 1125 would enhance the flexibility of the Chief Medical Director to organize the operation of the office in the way that best meets the needs of the Department's mission.

VA cannot support the particular provision in section 8 of S. 6 which would require that all persons appointed to positions in the Office of the Chief Medical Director be qualified in the administration of health services. Though it may be desirable to have persons in those positions with those qualifications, such qualifications are not clearly necessary for effectiveness in performing the job. In sum, although enactment of section 8 of the current S. 6 would improve the status quo, we strongly recommend that even greater flexibility be given to the Chief Medical Director, as the Administration proposal would do.

Enactment of section 8 would not impose new costs.

Section 9 of the bill would permanently prohibit the Administrator from declaring, as excess to the needs of the Veterans Administration, approximately 109 acres of real property at the VA Medical Center, West Los Angeles, and approximately 46 acres at the VA Medical Center, Sepulveda, California. As we indicated in our report on this measure, VA strongly objects to this provision.

VA recognizes its commitment to our Nation's veterans, which includes a commitment to the provision of medical care and treatment. VA medical centers are the focal point for this important mission, and we are constantly striving to improve the quality of care being provided veterans. VA's commitment extends both to current as well as future medical care needs. Section 9 of this bill would unduly restrict the Agency's ability to respond to these needs.

The continued availability of unused or underutilized property at VA medical centers which can be used to meet future VA requirements is essential. However, enactment of this proposal would be an unwarranted intrusion into the responsibilities of VA to manage the property of the Agency efficiently and effectively and in the best interest of America's veterans. Effective land utilization is a vehicle which can assist the VA to provide for these needs both today and in the future.

On June 6, 1986, the Administrator notified Congress of his intent to modify the Agency's original report and to declare as excess to VA needs approximately 80 acres at West Los Angeles and 31.8 acres at Sepulveda. The excessing recommendations have been fully assessed by VA, personally reviewed by the Administrator, and meet the criteria of 38 U.S.C. section 5022. The land proposed for excess is not needed now or for the foreseeable future by VA to fulfill its mission. We believe VA's decision to report this property excess reflects sound real property management and we request your support. Therefore, we urge the deletion of section 9 from the bill.

Section 10 of the bill would require that VA report to the Congress on VA activities to promote increased efforts by medical and health-professional training schools affiliated with VA to train individuals in the care of older patients, and to carry out research on aging, and diseases and disabilities associated with aging. The report would have to include very detailed information for academic years, from 1980 through the present, for all institutions affiliated with VA. Information would include the facilities or classroom training, geriatric training programs at the affiliated schools, geriatric rotation in VA facilities, costs of programs, estimates of VA patients receiving care from persons being trained in such programs, and descriptions of VA's role in encouraging such programs.

The information from this report could be useful. However, gathering the requested information from the affiliated schools would require a costly study and would force VA to collect information from affiliated schools about programs with which VA may have no involvement. We do not believe it would be cost-effective to undertake an effort of the scope contemplated by section 10, which requires that a great deal of very detailed information be gathered from the medical centers and over 1,000 affiliated schools. Accordingly, we cannot support section 10 as currently written. We recommend that it be modified to call for a survey of our VA medical centers to obtain information regarding the students who receive formal training in geriatric rotations through VA.

S. 631 - VA PROCUREMENT IMPROVEMENT ACT OF 1987

The purpose of S. 631, the "Veterans' Administration Procurement Improvement Act of 1987," is to enhance and support the process by which VA procures medical and pharmaceutical supplies. This bill specifically would require VA, within 3 years of its enactment, to develop and fully implement an Agency-wide plan for the standardization of all medical supplies and pharmaceuticals procured by VA; require VA medical centers to purchase these items through national contracts; require medical centers to enter into contracts with local vendors in certain situations; and require medical centers to report annually to the Administrator of Veterans' Affairs on all medical and pharmaceutical items or supplies procured annually by the medical center under a local contract.

VA places a high priority on the goal of ensuring the effective and efficient delivery of medical services to its patients and is already implementing a standardization program in the procurement process as a way to enhance that goal. At present, for the initial pilot test of the standardization program, VA is reviewing 32 classes of medical and pharmaceutical items for possible standardization. VA is also preparing a circular to establish a policy of analyzing and identifying items for possible standardization and to ensure that this process is ongoing. With the issuance of the circular, the standardization program will be "institutionalized" and be a continuous part of VA procurement decisions. We believe these efforts are indicative of VA's commitment to improve the process by which it procures medical and pharmaceutical supplies. Therefore, we believe this legislation is unnecessary. In light of that consideration and the fact that the provision would unduly limit needed flexibility in procuring often critically-needed items, we oppose its enactment.

More specifically, S. 631 would limit the procurement of medical and pharmaceutical supplies obtained during a fiscal year under local contracts to 20 percent, as contrasted to 80 percent procured under national contracts. We believe that the 20 percent limitation may be unrealistic, especially in view of new drugs and technologies which are not readily available in VA's depot system. This limitation does not appear to take into consideration bona fide medical emergencies or drugs which are required due to our affiliation with other hospitals. Second, the provision to require Medical Center Directors to submit a report involving line-item detail on local procurements would be a most difficult administrative burden until an automated procurement system could be implemented. Finally, we believe that some of the economies this bill is intended to achieve could be accomplished, however, by enacting an altogether different provision--one that would authorize VA to use multiyear contracts. S. 631 does not provide such authority, however. The enactment of such a provision would provide VA with significant cost savings in contract administration, in supplies, and in equipment.

S. 713 and S. 1195 - IMPROVE VA HEALTH-CARE PERSONNEL RECRUITMENT AND RETENTION

We would next wish to discuss the recruitment and retention of health-care personnel for VA, and legislation pending before the Committee, S. 713 and S. 1195. These bills offer a variety of specific measures aimed at improving VA's ability to hire and retain health-care personnel.

I would like briefly to outline the current conditions we are experiencing for some occupations in various locations, and actions under consideration to respond to these conditions, and to solve problems where they occur.

In an effort to improve our health-care personnel management, we undertook a survey in December 1986 to determine the status of recruitment and retention for 16 health-care occupations as of the end of FY 1986. This survey, along with information developed since that time, shows that we have significant localized recruitment and retention problems for Registered Nurses (RNs), Pharmacists, and Physical and Occupational Therapists. We are also concerned about potential difficulties in the radiologic and imaging science occupations and various technician positions.

The local problems we face in the recruitment area generally fall into the category of competition. Compensation levels are of primary importance, but to remain competitive, many health-care employers offer a number of additional benefits such as tuition assistance, continuing educational opportunities, day care for children, paid health and life insurance, recruitment bonuses, less stressful work environments, weekends off or additional compensation for weekend work. Often, VA fares well in this competitive arena, but sometimes difficulties exist, particularly in urban areas having a concentration of health-care employers.

Among the measures we have undertaken within our current authority, the Department has intensified the Special Salary Rates Program. Special rates are authorized when they are considered necessary to make VA more competitive (for the same occupational category) with the non-Federal labor market, to achieve adequate staffing, or to recruit personnel with specialized skills. As the Chief Medical Director, I can approve special rates for RNs, Physical Therapists and other Title 38 occupations. For Title 5 occupations, which include pharmacists, we must notify the Director of the Office of Personnel Management (OPM) 90 days in advance of an intended new or increased special rate authorization. To date, VA has typically experienced a 6-week review period before OPM concurrence is received. No authorizations have been turned down by OPM.

In addition to special rates, we have identified $2.5 million to be used in FY 1987 for tuition assistance specifically for those occupations and locations experiencing the most severe recruitment and retention problems. This would be in addition to the $4.5 million planned in FY 1988 for 240 Nursing scholarships. As a complement, we hope that Congress will provide for the authorization request contained in the FY 1988 budget to expand the VA Health Professional Scholarship Program to include $1.0 million for 55 scholarship awards for physical therapy students. We are convinced that expansion of the scholarship program would be beneficial to our recruitment and retention situation, and we appreciate your Committee's endorsement of this funding in your budget recommendations. Experience has shown that we have a high success rate with the program as 65% of the full-time nursing participants have remained in VA after completion of their obligated service requirement and 97% of the part-time participants have to date remained in VA.

While these programs are helpful, it is apparent that more needs to be done. Currently, the Department has an active Task Force that is charged with studying recruitment and retention problems, and with identifying long-term solutions. The Task Force is considering such potential measures as:

- Improved benefits packages;
- Increased recruitment budgets;
- Expanded use of Saturday premium pay under section 4107(e)(10) of title 38;
- Provision of recruitment bonuses for new hires;
- Streamlining the application process for Title 5 occupations, including the increased use of direct hire authority; and,

- Increased use of para-professional personnel.

Additionally, I am encouraging the development of a national program to enhance the image of VA as an employer. I believe we have been successful in informing the American public of our mission to provide the highest quality health care to the Nation's veterans. We now need to embark on a similar campaign to educate the health-care professionals, technicians, and other allied health personnel, both in and out of VA, about our system. We need to become highly visible in the "Employment Opportunities" section of newspapers and journals, particularly in the major metropolitan areas, and at job fairs. We need to let high school students, who are choosing colleges and possibly looking to health-care careers, know about VA as an employer. While this campaign will require the expenditure of time and funds, I believe that, in the long-run, it, along with other changes, will solidify VA's position as a national leader in health-care employment.

S. 713 - VETERANS' ADMINISTRATION REGISTERED NURSE VARIABLE INCENTIVE BONUS ACT OF 1987

S. 713 would authorize the Administrator of Veterans' Affairs to pay bonuses of up to $20,000 to individual registered nurses who agree to be employed by, or continue employment with, the VA's Department of Medicine and Surgery (DM&S) for a specified minimum period. Bonuses could be paid only to nurses who agree to work in designated geographical locations, or in a designated specialty in which VA has a significant recruitment or retention problem. For the reasons I will discuss, we do not favor enactment of S. 713 in its present form.

Under S. 713, bonuses could be paid only to registered nurses employed by VA under title 38, United States Code. A written service agreement between VA and the nurse would specify the geographic location and/or professional specialty in which the nurse would work. The Administrator would be required annually to determine specific geographic locations and professional specialties with recruitment and retention problems warranting use of the bonus program. No bonus could be paid to a nurse performing obligated service to VA under the Agency's Health Professional Scholarship Program. Bonuses could be paid to newly-hired nurses or those already employed by VA, and could be in any amount not exceeding $20,000. Bonuses could be paid in a lump sum, or in installments, and would be in addition to all other pay and allowances. A bonus would not be considered basic pay for determining amounts of other benefits nurses are entitled to, such as workers' compensation, retirement, insurance, or leave.

Under S. 713, the written agreement between the nurse and VA would also specify the period of full-time VA employment required in exchange for a bonus. The minimum service period permitted under the bill is three years. Failure to complete the service obligation would require the nurse to repay the bonus, or a prorated part of it based on the time actually served compared with the service period agreed to. Upon completion of the agreed service, the nurse would be eligible to sign another agreement and obtain another bonus.

As I mentioned earlier, we currently have a task force that is charged with studying recruitment and retention problems in the VA health-care system, and with identifying long-term solutions to those problems. Bonuses are one tool being considered by the task force for meeting employment needs in various health-care occupations, including registered nurses. The panel is considering both positive and negative aspects of a bonus program. For example, a bonus system would allow pinpoint targeting of dollars to specific recruitment and retention needs, and it could be approved and terminated in response to rapid changes in staffing needs. This "turn on, turn off" factor is complemented by the fact that bonuses would not affect employees' basic pay nor create a permanent increase in payroll. Bonuses would also allow VA to better compete for nursing services with those private sector hospitals which now pay bonuses. On the other hand, a bonus system such as that proposed in this bill could be considered inequitable in that it provides bonuses only to registered nurses, not for other occupations for which VA also has very severe recruitment and retention problems. The task force might also conclude that funds would be better spent in other more effective recruitment and retention programs.

We strongly urge that the Congress allow the task force to complete its work before acting on S. 713. We would also be pleased to work with the Committee in seeking solutions to VA's recruitment and retention problems. We estimate that the costs of implementing S. 713, if enacted, would be insignificant in the first fiscal year, and would be approximately $204.5 million over five fiscal years.

S. 1195 - VETERANS' ADMINISTRATION HEALTH-CARE PERSONNEL ACT OF 1987

There are six major provisions of S. 1195, the "VA Health-Care Personnel Act of 1987." Section 2 of the bill would allow VA to hire and pay registered pharmacists and occupational therapists under the title 38 personnel system, while other employment matters concerning pharmacists and occupational therapists, such as performance appraisal, leave, hours of duty, adverse action, and probationary periods, would continue to be governed under the provisions of title 5 of the United States Code. The main objective of this provision is to assist VA in recruiting and retaining these professionals. However, because we do not believe that this provision will significantly achieve this objective, we do not favor its enactment.

Section 2 of the bill is similar to provisions of Public Law 98-160, which allowed partial conversion to the title 38 system of respiratory therapists, physical therapists, and licensed practical/vocational nurses. At the time this legislation was passed, the Administration expressed concern that the special personnel authorities were unnecessary and costly and singled out VA for special treatment. It is our experience that the change in appointment authority for these professions did not significantly enhance recruitment and retention, except with respect to respiratory therapists.

The only practical advantage we find to this provision is granting VA authority to approve special rates for pharmacists and occupational therapists without the requirement for review by the Office of Personnel Management before the rates become effective. Based on our experience with Public Law 98-160, we estimate that this provision would result in a six- to eight-week reduction in the time required to process special rate requests. We do not see how this advantage is sufficient to justify this provision.

Section 3 of S. 1195 would require VA to provide premium pay to registered nurses for Saturday duty. Currently, section 4107(e)(3) of title 38 requires VA to pay a registered nurse additional pay up to 25 percent of the nurse's hourly rate of basic pay for duty on Sunday.

VA already has authority to provide premium pay to nurses for Saturday duty under section 4107(e)(10) and is now exercising this authority based on need. A Department Task Force charged with studying recruitment and retention problems has identified expanded use of this premium-pay authority as one element of a long-term solution to these problems. Furthermore, we believe that the section 4107(e)(10) authority is not only more flexible than section 3 of the bill, but it is directed specifically to meeting the main purpose of premium pay--to recruit and retain nurses for VA.

Therefore, we oppose section 3, not only because VA already has a more flexible premium-pay authority, but also because of the associated high costs of this provision. Presuming that the Saturday premium pay would be equal to that paid for Sunday premium pay, we estimate that the cost of this provision to be $21 million for Fiscal Year 1989 and a five-year cost estimate of $115 million.

Section 4 of the bill would require that Chiefs of Nursing Service or their designees be members of policy-making and fiscal committees, including those relating to budget, education, position management, Dean's committee, clinical executive issues, planning, and resource allocation at all VA health-care facilities. We do not believe that this is a matter that should be legislated, but should remain an agency responsibility. We are currently reviewing the Chief Nurse's role in facility management including membership on many of the committees included in this section.

Section 5 would establish a Health Professionals Educational Assistance Program. The first part of this Program would be a newly-established tuition reimbursement program to provide financial assistance to certain full-time nursing personnel, selected from those providing superior performance, for academic courses leading toward completion of any degree program in nursing or in a field related to nursing. VA could also provide tuition reimbursement for degrees to those providing direct patient-care services, or services incident to direct patient-care services, if it is determined that this program would help alleviate recruitment and retention problems.

An employee who has worked for VA for a minimum of two years full-time could receive a maximum of $2,000 a year, indexed to Federal pay raises, and would be required to work for VA for one year following completion of the degree or the last course taken while a participant in the reimbursement program.

As we discussed already, VA will initiate this year some tuition assistance for health-care professions and locations where there are recruitment and retention problems under the general training authority for Federal employees under title 5 of the United States Code. However, title 5 authorizes payment for training directly related to an employee's duties, but not for the specific purpose of obtaining a degree. Not only is the nursing profession emphasizing baccalaureate degrees, but many private hospitals are even offering tuition assistance to nurses for this purpose. A majority of VA facilities reported in a survey that their competitors offer tuition assistance as a fringe benefit. For these reasons, we favor this provision. We are somewhat concerned that the treble damages penalty may diminish the incentive value, for recruiting and retention, of the program. We estimate the first-year cost of the tuition assistance program to be approximately $5 million.

Section 5 would also provide VA with more flexibility to grant scholarships under the VA Health Professionals Scholarship Program by extending eligibility for these scholarships to all individuals accepted, or enrolled, as a student in a health-care program determined to be needed by VA.

Currently, eligibility for these scholarships is limited to individuals accepted for enrollment, or enrolled, as a student in a course of training leading to a degree in medicine, osteopathy, dentistry, podiatry, optometry, or nursing, or to become a physician assistant or expanded-function dental auxiliary. Section 5 would extend eligibility to include those seeking degrees for other health-care professions, such as pharmacists, psychologists, dieticians, occupational and licensed physical therapists, and licensed practical or vocational nurses.

The scholarship program has proven to be a highly successful method for recruiting and retaining health-care professionals for VA. Participants receiving these scholarships are obligated to work for VA upon completion of their training. The majority of those participants who finish their period of obligation remain with VA afterwards.

The current program does not provide VA the flexibility to grant scholarships to meet recruitment needs as shortages develop in other health-care professions, such as physical therapists, for which there currently is a shortage in VA. Accordingly, we favor this aspect of the proposal, which would assist VA in diminishing the adverse effects of future shortages for those health-care occupations we employ under title 38.

The bill would also, however, increase the period of obligated service for scholarship participants from one to two years for each year the student received a scholarship. It would also grant priority for receipt of scholarships by nursing students to those students who have completed three years of their nursing education. We have serious concerns that these two changes would greatly diminish the number of applications for scholarships, resulting in less qualified applicants. Accordingly, we object to those provisions of the measure.

Finally, we recommend that the method for computing the payback obligation for part-time students be amended to follow the revised formula enacted in section 213 of Public Law No. 99-576. If enacted, VA would expend an additional $1 million, as contemplated in the Fiscal Year 1988 budget, for scholarships for physical therapists.

S. 105 - AUTHORIZE INCENTIVE SPECIAL PAY FOR VA BOARD-CERTIFIED PSYCHOLOGISTS

S. 105 would authorize payment of incentive special pay to psychologists who are awarded board certification in clinical or counseling psychology by the American Board of Professional Psychology, or who have obtained an additional advanced academic degree which the Administrator determines would be in the best interest of VA.

Current law authorizes incentive special pay for VA physicians who have attained board certification in a medical specialty. The purpose of special pay, since it was initially established under Public Law 94-123 in 1975, has been to enhance VA's recruitment and retention of physicians. There is no persuasive evidence that VA is now experiencing problems recruiting and retaining psychologists so as to warrant providing incentive special pay to them. Accordingly, VA opposes the bill.

The bill would essentially provide VA psychologists a pay bonus if they obtain board certification and agree to work for VA for at least one year. We do not believe such a bonus is necessary to attract and maintain the number of highly-qualified psychologists needed for the VA health-care mission. The Administrator already has authority, under section 4107(g) of title 38, to increase rates of basic pay in order to alleviate local recruitment or retention problems, should they arise.

VA's Department of Medicine and Surgery employs a wide variety of health-care personnel who, like psychologists, may achieve a range of accreditations, certifications, and diplomas. In many of these professional fields, such as audiology and speech pathology, there is no additional compensation resulting from such attainments. In light of that fact, we believe it would be inequitable to give unique benefits to psychologists based solely on board certification.

VA estimates the cost of the special pay authorized by this bill as $2.22 million in the first fiscal year, and $11.1 million over the next five fiscal years.

MAJOR VA LEGISLATIVE PROPOSALS

As I indicated in my opening remarks, we are grateful that you have introduced draft legislation which we submitted to Congress this session. We welcome your active consideration of these measures. They include bills which would foster many of the goals this Committee stands for--providing VA the means to improve our health-care system, enabling it to administer health care more effectively, and to establish the most efficient management structures possible for that system.

Let me briefly highlight some of the measures we have initiated:

--S. 915 would promote VA's medical research and education programs by providing the Chief Medical Director with additional flexibility to appoint nonlicensed practical or vocational nurses, physical therapists and registered nurses to research or academic assignments. The waiver authority embodied in the draft bill is not intended for, and would not be used in connection with, any person who would have any responsibility for any patient. The draft bill would also assist the VA outpatient clinic in Manila to provide quality health care to veterans by permitting the appointment of temporary full or part-time practical or vocational nurses or physical therapists who are licensed only in the Philippines to serve in that facility.

-S. 939, entitled the "Veterans' Health Care Benefits Administration Act of 1987," would, through a series of amendments, remove statutory impediments that block access to VA care and help improve administration of VA medical programs. Among its provisions is a measure that would achieve the purpose of S. 894 to permit foreign nationals who were disabled while serving as members of U.S. Armed Forces to obtain VA-sponsored health care for those disabilities without regard to citizenship. S. 939 would also provide needed authority to arrange for emergency hospital care needed by veterans who have been undergoing community nursing home care at VA expense.

-S. 1062 would clarify the authority of the Chief Medical Director or designee to accept, reject, or modify recommendations made by Professional Standards Boards as a result of their reviews of the performance of probationary medical professionals. Currently, the Chief Medical Director, who is the official responsible for the operation of the Department of Medicine and Surgery, plays no substantive role in this review process. This provision would clarify the intent of Congress that the Administrator has the power to prescribe by regulation both the procedures to be followed by the Board and the circumstances in which Board proceedings may be initiated and that final action in the review process should be taken by the Chief Medical Director. Also, this provision would authorize these Boards to recommend corrective action other than the requirement in section 4106 that an employee be removed for unsatisfactory performance. This proposal would provide flexibility to allow the reviewing body to tailor its recommendations to fit the particular circumstances of each case.

-S. 1064 would extend the Agency's authority to provide adult day health care services, which will otherwise expire on September 30, 1988. We see this program as providing a very promising alternative to institutionalization.

-S. 1065 would solve a series of problems in ensuring that certain title 5 health-care personnel, such as x-ray, laboratory, operating room and other technologists and technicians are available in medical emergencies or for unforeseen medical needs that occur outside their regular duty hours by authorizing the Administrator to pay "on call" pay to civil service health-care personnel in the same manner that this pay is provided to title 38 registered nurses. Under this bill, VA could schedule these health-care personnel "on call" as necessary without instituting costly standby pay.

-Our proposal, S. 1125, to authorize modification of the structure of the Office of the Chief Medical Director, which we discussed earlier in connection with S. 6.

-S. 1136 would amend section 4110 of title 38 to limit the appointment of disciplinary boards to cases where the proposed penalty is removal, suspension of more than 14 days, or demotion involving loss of grade or pay. By implication, all lesser disciplinary actions would be excluded. Administrative appeal or grievance procedures would be established for these latter actions under regulations prescribed by the

> Administrator pursuant to current authority. As a result, the volume of section 4110 disciplinary actions would be reduced, which will in turn reduce processing time for an average case. Further, lesser disciplinary actions could be more efficiently utilized as part of an effective progressive disciplinary approach. In addition, S. 1136 would allow for delegation of the CMD's authority to appoint disciplinary boards to other officials. This bill would also allow the CMD to redelegate authority from the Administrator to appoint a chairman and secretary to the disciplinary board and to receive and act upon recommendations of the board. It would not, however, affect the existing right to appeal a decision to the Administrator. Absent such an appeal, the decision of the Chief Medical Director or designee would have the same force and effect as a decision of the Administrator. Decentralizing the disciplinary board process will expedite board results.

We have also submitted a number of measures which may be viewed as relatively technical in nature. Their enactment, nevertheless, is important. These proposals include:

-S. 914, entitled the "VA Health Care Amendments Act of 1987," would, for example, clear up a troublesome issue surrounding the definition of the term "nursing home care" to provide that that term includes both skilled and intermediate levels of care.

-S. 916 would provide the Administrator with clear statutory authority to disclose the names and addresses of veterans to individual Members of Congress for title 38 benefits purposes, and clarify the authority of the Administrator to approve the disclosure of names and addresses from VA records for the purposes of conducting field examinations, investigations, or other inquiries authorized for title 38 benefit programs, or under the Inspector General Act.

-S. 1063, a measure aimed at improving hospital cost collections and resolving problems in administering tort claims. The bill would clarify the statute of limitations applicable to suits brought by the United States to recover its costs of VA health care, pursuant to 38 U.S.C. § 629. It would also expand the immunity from personal liability for VA health-care personnel to that afforded health-care personnel of other agencies. Finally, the measure would remove a statutory limitation on the authority of the Administrator to settle administrative tort claims under the Federal Tort Claims Act.

-S. 1089 would revise the process of awarding grants under the State veterans home program to permit the Administrator to give conditional approval to, and obligate funds for, a State home project before all requirements for a grant are met. This measure would give States sufficient time to meet all grant requirements and therby avoid inequities in the grant award process.

RESOLUTION APPROVING MAJOR VA CONSTRUCTION PROJECTS

Finally, we ask that the Committee adopt a resolution to approve VA's request for FY 1988 to engage in major medical projects.

The VA health-care system is made up of 172 medical centers, 120 nursing home care units, 17 domiciliaries and 53 independent and satellite outpatient clinics. This system operates in over 5,000 separate buildings, with over 100 million square feet of space. As you know, these buildings represent a tremendous capital investment. VA must maintain a physical plant capable of delivering state of the art medical care, one which can keep pace with modern medical advances and respond to the changing needs of the veteran population. Our construction program represents a commitment to a capital investment program which is dedicated to meeting the facility needs of a modern, comprehensive health-care delivery system to provide for our Nation's veterans.

In keeping with that commitment, VA's obligations in actual dollars over the past five years for its construction program have exceeded that for any previous five year period in VA's history. In the period from Fiscal Year 1982 through Fiscal Year 1986, VA obligated over $2.6 billion. This is an increase of almost $1.0 billion over obligations in the previous five-year period. We are maintaining our commitment with the 1988 construction request of $525.7 million.

Specifically, the FY 1988 budget requests a program level of $525.694 million. This amount includes an appropriation request for major projects of $400.556 million, a minor program of $121.038 million and a parking garage revolving fund of $4.1 million. We are requesting approval for funding 15 major projects, $18.5 million for the advance planning fund, $25.0 million for asbestos abatement and $14.2 million for the design fund. The request includes funding for construction of major replacement facilities at Dayton, Ohio, and North Chicago, Illinois. The project at Dayton will provide for a new replacement 476-bed hospital, while the North Chicago project provides for major renovations, a new clinical addition, as well as an increase in North Chicago's nursing home bed capacity from 190 to 360 beds. We also are requesting funding, in Fiscal Year 1988, for the design of a clinical addition/parking garage project at Atlanta, Georgia; design and site preparation for a new 400-bed medical center in Palm Beach, Florida; and funds for phase I construction of a replacement medical center in Pittsburgh (Aspinwall), Pennsylvania.

In addition, this budget request includes two clinical improvement projects, three fire and safety improvements projects, one domiciliary project, one outpatient improvements project, one national cemetery project and one regional office project, and the relocation of the Wichita regional office onto medical center grounds. This project has been subject to extensive cost benefit analysis and is in the best economic interest of the Government. Our minor costruction program request of $121.038 million includes $63 million for the construction of medical-related programs. Included in this request is $4.5 million for the conversion of 189 existing hospital beds to nursing home beds. The FY 1988 minor construction request also includes $3.06 million for the regional office program, $6.02 million for the national cemetery program, $6.22 million for staff offices and $42.738

million for general administration. The requested increase in general administration is primarily the result of increased pay costs due to the new Federal Employee Retirement System and the recent pay raise.

The FY 1988 medical facility construction budget request is a product of the planning and development efforts of the Department of Medicine and Surgery and the Office of Facilities. The Medical District Initiated Program Planning Process (MEDIPP) serves as the initial programmatic basis of construction planning in VA. Through this process, the VA's 27 medical districts, using state of the art planning tools and guidance provided from the Chief Medical Director, develop plans to provide services to those veterans who use the VA health-care system. These plans, which identify medical programs and levels of service, are reviewed, modified (if necessary) and approved in VA Central Office. This serves as the basis for the development by each medical center of a five-year facility plan--a plan which identifies facility requirements and projects to correct deficiencies and to provide the necessary physical plant to meet programmatic objectives.

We have recently begun the implementation of a major initiative which we believe will significantly improve our facility planning process. This initiative, recommended by the Booz, Allen and Hamilton/RTKL report, is the establishment of a facility development plan (FDP) for each VA medical center. An FDP is a written comprehensive plan for the physical development of each medical center over a specific planning horizon. VA has begun by testing the FDP application at four medical centers: Marion, Illinois; Marion, Indiana; Long Beach, California; and Northport, New York. These pilot tests began in January 1987, and will serve to guide VA in the wider application of the FDP concept to all medical centers.

Current plans envision beginning FDP development at 40 VA medical centers in the fourth quarter of FY 1987, and funds have been provided in the Fiscal Year 1987 appropriation for this purpose. The FY 1988 budget contains, as part of the advance planning fund request, an additional $10 million to begin 40 more FDP's. In FY 1989, it is expected that the FDP's for all remaining VA medical centers will begin. The total cost for the FDP's required systemwide is estimated to be between $30 and $40 million. The facility development plans will serve as the basis for the preparation of a five-year plan for each medical center and in the aggregate will guide national resource distribution planning in the construction arena. The data produced through the FDP process will be valuable to the Agency in assessing overall capital requirements and in establishing priorities. We would be pleased to keep the Committee informed of our progress in this area.

AIDS

You have also asked us to discuss VA's experience with Acquired Immunodeficiency Syndrome (AIDS).

AIDS was first recognized in the U.S. in 1981. Reporting of AIDS cases in VA began in 1983, and at the end of that year, 211 cases of AIDS had been reported. With the start of FY 1987, 1,396 cumulative cases had been reported. By April 30, 1987, the number had risen to 1,942 cases. Most of those cases were in VA Medical Centers in the New York metropolitan area, San Francisco, Miami, and San Juan. By the end of FY 1987, VA will have cumulatively seen approximately 3,000 cases since the begining of the epidemic. About 55-60% of these patients will have died by that time. In FY 1988, VA could conceivably have an additional caseload of 1,000 cases.

One hundred-nine (109) medical centers have reported providing care to AIDS patients. However, 55% of all reported cases have been in 10 medical centers located in the epicenters of the disease. A 1-day patient census was done October 30, 1986, and revealed 136 patients hospitalized at 24 medical centers.

It is estimated that medical care for AIDS in VA costs in the range of $25,000 per year per patient. The length of hospital stay (LOS) varies with demographics and the availability (or nonavailability) of social support networks in the community. In our medical centers, more care is being shifted to the outpatient department, particularly where adequate social support systems exist for home or noninstitutional care.

The disease known as AIDS is really a syndrome of many diseases, and the diagnostic and therapeutic resources required vary dramatically. A new development which is having a tremendous effect on funding is the release of the new drug zidovudine (formerly AZT) at a cost of $225 per bottle. Each bottle contains 100 tablets. As the usual dosage per day for the patient is 12, a year's supply approaches $10,000 for the drug alone. A survey recently conducted by Central Office Pharmacy Service revealed, of the 103 medical centers responding, that, as of April 15, 1987, 125 VA patients were on zidovudine, with a projected 438 patients by June 30, 1987. In FY 1988, the of patients on zidovudine could be nearly 1,000. AIDS diagnosis may require sophisticated equipment such as cell counters, flow cytometers and scanning devices. These patients also require more mundane equipment such as ventilators, endoscopes, etc., as well as disposable and routine lab supplies/equipment.

Another significant cost component arises from efforts to screen for human immunodeficiency virus (HIV) antibodies. The cost of the testing is only a small part of a responsible screening program. The provision of pre- and post-screening counseling is far more costly and more difficult. Follow-up must be provided and confidentiality assured.

We recognize that our prospective payment system is not structured to provide proper funding for AIDS cases. AIDS and ARC (AIDS Related Complex) do not have a specific DRG (Diagnostic Related Group) and it is estimated that, in a year, the costs in VA will exceed the earned reimbursement for specific DRGs by approximately $20,000 per case. In VA, the DRGs "earned" establish the budget for 2 years from now. This does not take into account the steadily rising case load that is being predicted for the foreseeable future. Recognizing this problem, my staff has been reviewing cost accounting and reimbursement methodologies for resolving it.

We are working on many fronts in the AIDS' battle. Currently thirty-five VA laboratories are actively engaged in research related to AIDS and human immunodeficiency virus (HIV) infection. In addition, we expect that two special initiatives to solicit additional HIV research will add significantly to VA's research portfolio in this important area. A special solicitation to VA researchers, dated March 30, 1987, announced support for individual research projects on HIV infection and related subjects. These projects will be reviewed in VA Central Office by a special committee of HIV experts in

November, 1987; successful projects will be funded in April, 1988. It is anticipated that 50 new, high-quality research studies will be supported through this solicitation. A second solicitation is about to be issued, announcing support for up to three AIDS Research Centers. VA medical centers that have significant expertise in research in HIV and related infections are encouraged to apply for additional core research support through this solicitation. Successful Center applicants will receive support for a physician director position, a Ph.D. scientific director position, plus approximately $100,000 core research support annually for five years. The VA AIDS Research Centers will be selected by a peer review panel in late 1987, for funding in the Spring of 1988. These two AIDS research initiatives will significantly expand VA's current strong research program in HIV infection.

There are other less dramatic, but still important, initiatives underway. These include cooperation with other agencies, particularly DoD, development of educational programs for staff and patients. We are also working with VA's Department of Veterans Benefits in developing rating guidelines for those discharged from the military with the AIDS infection. These and other activities are being coordinated through a task force on AIDS.

Many questions regarding AIDS are yet unanswered including how many of those currently infected with HIV will develop AIDS and ARC. Most of the patients are young men (average age 40 years) who would ordinarily be light users of health care. It has been estimated that only 50% of the patients diagnosed with AIDS survive a year after diagnosis. However, zidovudine appears to lengthen this period somewhat so that survival predictions are uncertain at present. It is undoubtedly the first of many such drugs which will be developed before a cure is found. While these drugs will bring some hope, they will also require more intensive treatment and surveillance of the patients.

Mr. Chairman, this concludes our testimony. My colleagues and I would be pleased to respond to any questions you may have.

DM&S POLICY DIRECTIVES

CIRCULAR 10-84-103
SUPPLEMENT NO. 3
February 10, 1987

TELEGRAPHIC MESSAGE

NAME OF AGENCY VACO, WASHINGTON, DC	PRECEDENCE ACTION: P INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED 1/21/87	FILE
FOR INFORMATION CALL		
NAME YVONNE K. MOODY	PHONE NUMBER 233-3527	TYPE OF MESSAGE ☒ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS

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MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

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00/DM&S THIS IS DM&S SUPPLEMENT NO. 3 TO DM&S CIRCULAR 10-84-103 (DTD: 2-10-87)

SUBJ: CLASSIFICATION OF EXTENDED CARE PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS (RCS 10-0624)

1. PURPOSE: THE PURPOSE OF THIS DM&S SUPPLEMENT IS TO EXTEND DM&S CIRCULAR 10-84-103 TO JUNE 30, 1987.

2. DM&S CIRCULAR 10-84-103 AND THIS SUPPLEMENT EXPIRE ON JUNE 30, 1987. THIS CIRCULAR WILL BE INCORPORATED INTO DM&S MANUAL M-2, PART V BY CHANGE 1 DATED JANUARY 15, 1987, WHICH CURRENTLY IS BEING PRINTED. THIS SUPPLEMENT WILL NOT BE CONFIRMED WITH A PRINTED COPY.118C/11J/11/10

Arthur J. Lewis

ARTHUR J. LEWIS, M.D.
Acting Deputy Chief Medical Director

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CIRCULAR 10-84-24
SUPPLEMENT NO. 2
February 10, 1987

TELEGRAPHIC MESSAGE

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SUBJ: CLASSIFICATION OF MEDICAL/SURGICAL PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS

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CIRCULAR 10-85-82
SUPPLEMENT NO. 2
February 10, 1987

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SUBJ: CLASSIFICATION OF CRITICAL CARE PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS

1. PURPOSE: THE PURPOSE OF THIS DM&S SUPPLEMENT IS TO EXTEND DM&S CIRCULAR 10-85-82 TO JUNE 30, 1987.

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CIRCULAR 10-85-164
SUPPLEMENT NO. 1
February 10, 1987

TELEGRAPHIC MESSAGE

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ACCOUNTING CLASSIFICATION	DATE PREPARED 1/21/87	FILE
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SUBJ: CLASSIFICATION OF PSYCHIATRIC PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS (RCS-10-0034)

1. PURPOSE: THE PURPOSE OF THIS DM&S SUPPLEMENT IS TO EXTEND DM&S CIRCULAR 10-85-164 TO JUNE 30, 1987.

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Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

CIRCULAR 10-84-24

February 17, 1984

TO: Regional Directors; Directors, All DM&S Field Activities

SUBJ: CLASSIFICATION OF MEDICAL/SURGICAL PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS

1. This circular includes significant and extensive changes from the previous expired DM&S Circular 10-82-51, dated April 5, 1982.

2. The purpose of this Circular is to provide instructions for health care facilities to classify Medical/Surgical patients according to their nursing care needs. This methodology for Nursing Service will be based on classification of patients according to their nursing care requirements, related to patient dependency and amount of direct nursing care provided. This patient classification methodology will be used on Medical/Surgical Units only. Nursing Units excluded are Spinal Cord Injury, Critical Care Units, Intermediate Medicine, Psychiatry, and Nursing Home Care Units.

3. The classification has been fully tested and validated. Instructions have been developed and effective application of the methodology will depend upon proper classification of the patient. A suggested procedure to ensure inter-rater reliability is included as Attachment D.

4. The Nursing Service of each hospital will classify patients according to the attached criteria. Patients will be classified on Medical/Surgical bed sections each day. After familiarity with the classification system, this procedure will be accomplished in a matter of seconds. The classifier should be a registered nurse who knows the patient. A second registered nurse should periodically sample and evaluate the classification process.

5. The Automated Management Information System (AMIS) will continue to be used as the nursing service reporting mechanism. (Instructions for AMIS, MP-6, Part VI, Supplement No. 1.2, Change 170, November 8, 1979). A major difference from the present categorization is that Category I-II-III-IV will be reversed for Medical/Surgical bed sections. For example Category I is minimal care and Category IV requires intensive nursing care.

6. It is a requirement that the classification of each patient be verified at 3:00 P.M. every day by the head nurse or designee.

7. Medical/Surgical Patients will be classified using this system for the AMIS Report (RCS 10-220).

John A Gronvall, M.D.
JOHN A. GRONVALL, M.D.
Deputy Chief Medical Director

Attachments

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THIS CIRCULAR EXPIRES FEBRUARY 28, 1985

CRITERIA FOR CLASSIFYING MEDICAL/SURGICAL PATIENTS ACCORDING TO NURSING CARE REQUIREMENTS

INSTRUCTION GUIDE

Criteria have been prepared to classify patients into one of four categories according to their individual nursing care needs. The categories range from minimal nursing care, Category I to more intensive nursing care, Category IV.

PURPOSE OF CLASSIFICATION:

To determine the number of patients classified into each of four categories that represent requirements for nursing care and to serve as a measure for staffing medical/surgical bed sections.

PROCEDURE FOR CLASSIFYING PATIENTS:

1. VA Form 10-0005, Patient Classification Card, will be used for each patient (see p. C-1). This classification card will be imprinted with the patient identification information and placed in the Nursing Care Plan (such as Kardex).
2. Newly admitted patients will be classified upon admission.
3. Each registered nurse will classify assigned patients on each tour of duty.
4. Category of each patient will be verified at 3:00 p.m. every day by the head nurse or designee.
5. Data should be reported according to AMIS instructions.

GENERAL INSTRUCTIONS:

1. Using the attached definitions and instructions, the patient will be placed in the category which best identifies individual nursing care needs.
2. Sufficient information is provided in this Circular for the use of the classification instrument. More detailed information is available in DHEW Publication No. HRA 79-3.

ATTACHMENT B

CIRCULAR 10-84-24
February 17, 1984

DEFINITIONS AND INSTRUCTIONS

SPECIAL GUIDELINES FOR PATIENT CLASSIFICATION

Items indicating needs for care	Instructions
1. Activity Independent	Checked if patient takes own bath (basin at bedside, tub, or shower) with minimal supervision; manages own personal hygiene even if on maintenance IV., catheter, etc.; moves from bed without help. This item should not be checked if any of the following items number (2) through (6) are checked.
2. Bath, Partial Assist	Patient can start own bath, but not complete it. Needs help to get to shower or tub, and/or supervision and encouragement during bath. If patient needs help only to wash back, this item should not be checked; if patient requires complete bed bath, it should not be checked.
3. Position, Partial Assist	Patient can assist in turning or positioning in bed; cannot move independently from bed to chair. Needs help in maintaining proper alignment (e.g., traction, foot board).
4. Position, Complete Assist	Needs complete assistance in turning, positioning, and propping in bed or chair. This item also assumes patient cannot help with own bath. Only "Partial" or "Complete Assist" should be checked, not both.
5. Diet, Partial Assist	Can feed self after help in opening cartons, cutting meat, etc. May require supervision and encouragement to eat.
6. Diet, Feed	Must be fed, or may need constant supervision and encouragement due to swallowing difficulty. Gastric gavage or gastrostomy tube feeding. Only "Partial Assist" or "Feed" should be checked, not both.
7. I.V. additive every 6 hours or more, or I.V. to be kept open	I.V. to be kept open (TKO) which requires frequent monitoring may be checked here even if patient is independently active.

8. Observe every 1-2 Hours	Requires symptom observation and monitoring over and above I.V. checks and every 2-4 hour vital signs, e.g., hourly output, 15-minute neurological checks, vital signs until stable after surgery or diagnostic procedure.
9. Observe, Almost Constant	In addition to the above, requires almost constant observation due to special equipment, complex treatments and/or problems. Only one or the other of the "Observe" items should be checked. If a patient requires constant observation, this fact, in most instances, will classify the patient as class IV regardless of the number of checks in each column.
Item Entries and Weighting Factors	Place check marks in each column (I, II, III, and IV of an item/factor that appropriately describes the patient. For example, if Position Partial Assist describes the patient, checks are placed within white boxes of Column II and III for that item. Preexisting checks in columns I and II and the preweighting of .5 under column III should be counted when adding columns. Enter sum of each column in row marked "Total".
Total:	The number of checks is added and the total each column is entered, retaining the .5 weighting factor in column III. The patient classification (I, II, III, or IV) is circled at the top. If the columns have the same total, the higher classification is noted. The highest total possible is 5.5, which could be summed for column III.
Comments:	Use this space to record special situations which may warrant a higher classification than is circled. For example, a patient in isolation, smoking hazard, or wanderer.

ATTACHMENT C

CIRCULAR 10-84-24
February 17, 1984

Following is an example of a completed Patient Classification form, VAF-10-0005. Category I consists of minimal care patients; Category II, average/moderate care patients; Category III, above average/considerable direct care; Category IV, intensive care.

The patient's name, bed number, unit and date are entered at the top of the form.

Those item(s)/factor(s) which best describe a given patient are checked in all columns in the corresponding row for the item(s). For example, if "I.V. Add q6h or more or TKO" describes the intra-venous fluids being received by the patient, check marks are placed within the white boxes of columns II, III and IV of that row.

Preexisting checks in columns I and II and the preweighting of .5 under column III are used to prevent ties. The number of checks in each column are added vertically and then entered in the row marked "Total" under the appropriate column.

The column with the greatest number of checks is the patient's classification. The category should be circled at the top of the form under the row marked "Patient Classification".

NURSING
PATIENT CLASSIFICATION FORM

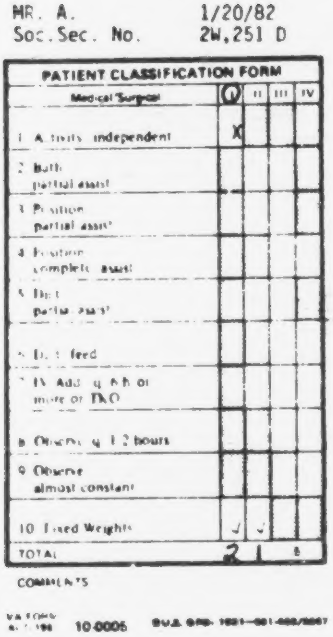
MR. RICK 3/1/82
Soc. Sec. # 491-03-8117
4N.4200

PATIENT CLASSIFICATION FORM

Medical/Surgical	I	[✓ II]	III	IV
1 Activities independent	X			
2 Bath partial assist				
3 Position partial assist				
4 Position complete assist				
5 Diet partial assist				
6 Diet fed				
7 IV Add q 6 h or more or TKO		X	X	X
8 Observe q 1-2 hours				
9 Observe almost constant				
10 Fixed Weights	✓	✓		
TOTAL	2	2	1.5	1

COMMENTS:

VA FORM
AUG 198 10-0005 *U.S. GPO: 1981—[illegible]



MR. A. 1/20/82
Soc. Sec. No. 2W,251 D

PATIENT CLASSIFICATION FORM

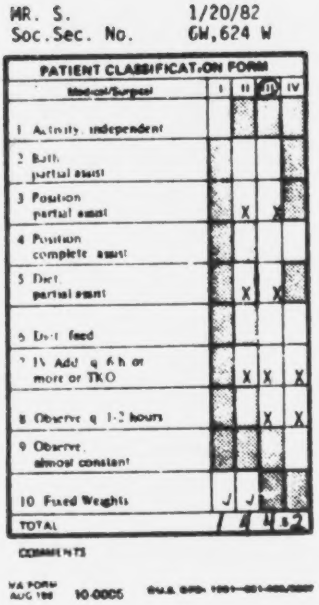
Medical Surgical	[✓ I]	II	III	IV
1 Activity independent	X			
2 Bath partial assist				
3 Position partial assist				
4 Position complete assist				
5 Diet partial assist				
6 Diet feed				
7 IV Add q 8 h or more or TKO				
8 Observe q 1-2 hours				
9 Observe almost constant				
10 Fixed Weights	✓	✓		
TOTAL	2	1		8

COMMENTS

VA FORM 10-0005

CASE:

Mr. A., 51 y/o admitted to medical unit with dx: ascites.
V.S. q8h; daily weight; feeds self after tray is served.
Ambulates self with wheelchair; Check stools for occult blood.



MR. S. 1/20/82
Soc.Sec. No. GW,624 W

PATIENT CLASSIFICATION FORM

Medical/Surgical	I	II	[✓ III]	IV
1 Activity, independent		▨	▨	▨
2 Bath, partial assist	▨			▨
3 Position partial assist	▨	X	X	▨
4 Position complete assist	▨			
5 Diet, partial assist	▨	X	X	▨
6 Diet, feed	▨			
7 IV Add. q 6 h or more or TKO	▨	X	X	X
8 Observe q 1-2 hours	▨		X	X
9 Observe, almost constant	▨	▨	▨	
10 Fixed Weights	✓	✓	▨	▨
TOTAL	1	4	4	2

COMMENTS

VA FORM AUG 198 10-0005 [illegible]

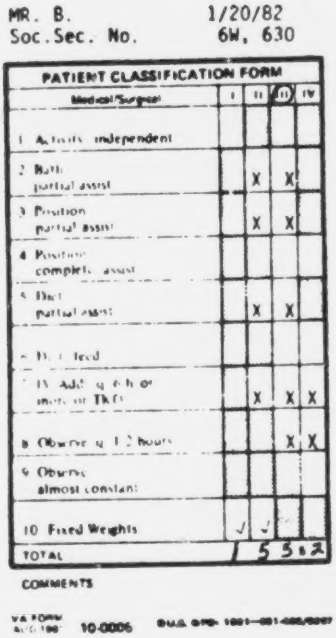
CASE:

Mr. S., 63 year old bilateral above the knee amputee admitted to surgical unit with abdominal pain status post Ileo resection with ileostomy and mucous fistula (Post-op day #6).

Vital signs q8h; daily weight. Requires close observation due to dehydration and weakness (at least q2-3h) Low soduim diet; requires constant encouragement to take fluids and nourishment, feed self.

NS with Potassium via I.V. - requires close observation and frequent reposition of arm to maintain rate and patency.

Up in chair - must be observed.
Wet to dry abdominal dressing q8h.
Trach, ileostomy care; depressed and needs much encouragement.
Bathes self.



MR. B. 1/20/82
Soc.Sec. No. 6W, 630

PATIENT CLASSIFICATION FORM

Medical/Surgical	I	II	[✓ III]	IV
1 Activity independent				
2 Bath partial assist		X	X	
3 Position partial assist		X	X	
4 Position complete assist				
5 Diet partial assist		X	X	
6 Diet fed				
7 IV Add q 6 h or more or TKO		X	X	X
8 Observe q 1-2 hours			X	X
9 Observe almost constant				
10 Fixed Weights	✓	✓		
TOTAL	1	5	5	2

COMMENTS

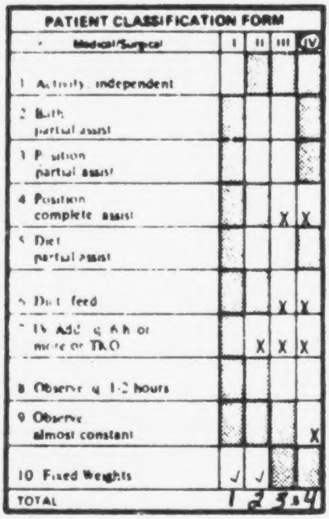
VA FORM [illegible] 10-0006 [illegible]

CASE:

Mr. B., 63 year old surgical patient admitted with necrotic colon.
Status Post Ileostomy and colon resection (Post-op day #4).
Vital signs every shift.
Ambulate with assistance.
To physical therapy daily - to walk using walker.
Daily weights.
I and O: Sugar and Acetone and Specific Gravity every shift.
Regular diet and nutritional supplements every 2 hours.
Poor appetite - needs encouragement.
Rectal sump to wall suction; irrigate q4h.
Change abdominal dressing q8h.
Assist with bath.
Normal Saline 100cc/hr via peripheral I.V.
Hyperalimentation fluid via central line.
Intralipids qd.

CIRCULAR 10-84-24
February 17, 1984

MR. J. 1/20/82
Soc.Sec. No. 2W,216



PATIENT CLASSIFICATION FORM				
Medical/Surgical	I	II	III	(IV)
1 Activity independent		▨		
2 Bath partial assist	▨			▨
3 Position partial assist				▨
4 Position complete assist	▨		X	X
5 Diet partial assist	▨			
6 Diet feed	▨		X	X
7 IV Add q 6 h or more or TKO		X	X	X
8 Observe q 1-2 hours				
9 Observe almost constant	▨			X
10 Fixed Weights	✓	✓	▨	▨
TOTAL	1	2	3	4

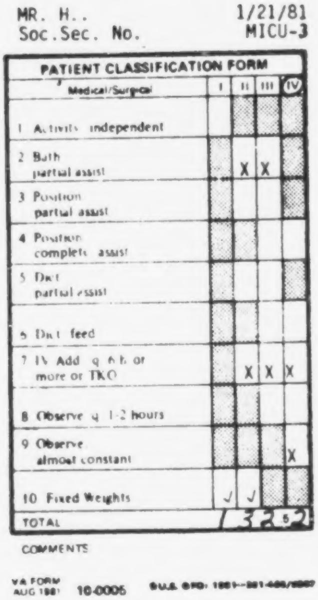
COMMENTS

VA FORM AUG 1981 10-0006

CASE:

Mr. J., 67 y/o patient on a medical unit with COPD and tracheostomy.

Unresponsive and requires total care.
VS q4h; I and O; turn q2h; water mattress; special skin care; up in chair q day; Range of Motion tid.
External catheter; incontinent.
Tracheostomy care q8h with frequent suctioning (at least q1h); 26% 0_2 with mist via T-tube; Arterial/Blood gases qd.
Continuous tube feeding - check residual q8h.
Pilonidal cyst requires irrigation ½ strength peroxide q8h.
Continuous IV fluids; IV meds.



MR. H..
Soc.Sec. No.

1/21/81
MICU-3

PATIENT CLASSIFICATION FORM

Medical/Surgical	I	II	III	(IV)
1 Activity independent		▨	▨	▨
2 Bath partial assist	▨	X	X	▨
3 Position partial assist	▨			▨
4 Position complete assist	▨	▨		
5 Diet partial assist	▨			▨
6 Diet feed	▨	▨		
7 IV Add q 6 h or more or TKO	▨	X	X	X
8 Observe q 1-2 hours	▨	▨		
9 Observe almost constant	▨	▨	▨	X
10 Fixed Weights	✓	✓	▨	▨
TOTAL	1	3	2	5 2

COMMENTS

VA FORM
AUG 1981 10-0005 ☆U.S. GPO: 1981—[illegible]

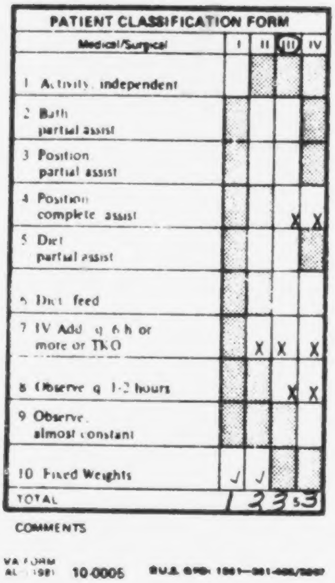
CASE:

56 year old male admitted to MICU on June 20, 1981, with chief complaint of crushing chest pain. Admitting acute inferior wall myocardial infarction. Mr. H. is in the step down unit and ambulating 3 times a day within his room. Partial assistance is required for daily hygiene.

He is maintained to keep vein open with IV additive and additional medication of Digoxin, Lasix, Vallium, Nitroglycerin, Nitro Paste.

Daily lab tests and EKG's are required. Doctor visits 3 times a day and nurse intervention requires continuous cardiac monitoring.
Frequent emotional support, cardiac assessment and patient education.

MR. J.
Soc. Sec. No.



PATIENT CLASSIFICATION FORM

Medical/Surgical	I	II	[✓ III]	IV
1 Activity, independent		▨	▨	▨
2 Bath partial assist	▨			▨
3 Position partial assist	▨			▨
4 Position complete assist	▨		X	X
5 Diet partial assist	▨			▨
6 Diet feed	▨			
7 IV Add q 6 h or more or TKO	▨	X	X	X
8 Observe q 1-2 hours	▨		X	X
9 Observe, almost constant	▨	▨	▨	
10 Fixed Weights	✓	✓	▨	▨
TOTAL	1	2	3	s3

COMMENTS

VA FORM
AL 1981 10-0005 *U.S. GPO: 1981-[illegible]

CASE:

Mr. J., is a 62 year old male admitted on June 4, 1981, for a left below the knee amputation secondary to a gangrenous left foot.
The surgery was yesterday without complication. Mr. J., one day post- op, is on complete bedrest with IV to keep vein open and IV antibiotics. He requires total physical support for daily hygiene and positioning; left leg dressing is changed q 12 hours or as needed.
Nutritional support is by IV only due to existing nausea and vomiting.
Vital signs: temp.-101.2, pulse-98, resp.-26, BP-152/98; complaint of severe pain in left leg and is medicated every 4 hours PRN. Frequent vital signs and symptom checks.

ATTACHMENT D

SUGGESTED PROCEDURE TO ENSURE INTER-RATER RELIABILITY AMONG NURSES IN CLASSIFYING MEDICAL/SURGICAL PATIENTS

Why is Inter-rater Reliability Important?

The determination of workload and nurse staffing requirements are dependent on accurate classification of patients. Inter-rater reliability is a method to establish and maintain consistency in the way nurses classify patients both within an individual nursing unit and among all similar units at each hospital.

In order to check on the internal consistency of the patient classification system, an evaluation of inter-rater reliability must be conducted. Since accurate assessments of patient classification are an integral component in the determination of required nursing hours, the reliability of the patient classification process should be evaluated periodically and corrective measures should be taken when indicated as part of an ongoing program.

Purpose and Scope

The purpose of this procedure is to measure and minimize variability in the way different nurse raters classify the same kinds of patients using the current medical/surgical patient classification system. The procedure is directed at achieving a high level of consistency in patient classification or inter-rater reliability within a health care facility. Efforts to measure and attain high inter-rater reliability among different hospitals within the VA health care system may be taken at a later date.

Who Should Perform this Function?

The success of the patient classification system and the evaluation of inter-rater reliability is dependent upon knowledge of the system and a commitment to it by each nurse who is involved. A registered nurse, designated by the Chief, Nursing Service, should be assigned the overall responsibility to evaluate levels of inter-rater reliability. The nurse assigned this responsibility may be in either a staff role or a management position. This determination should be based on the organizational structure of the Nursing Service and the availability of resources. Nurses who should be considered are Nursing Instructors, Clinical Nurse Specialists, Nursing Supervisors, and Head Nurses.

Two additional nurses, designated by the Chief, Nursing Service, should be assigned to assist the nurse who is responsible for this project. Assistants should have a thorough knowledge and demonstrate competence in the nursing care requirements of medical/surgical patients and the patient classification system. These nurses should also demonstrate consistency in the manner in which they classify patients.

CIRCULAR 10-84-24
February 17, 1984

Process

This approach is based on evaluating the consistency of patient classification among nurses, and working with individual nursing units until acceptable levels of consistency are achieved. A reduced frequency of review is then performed to ensure continued high levels of reliable patient classification.

The proposed frequency and scope for evaluation consistency is outlined below:

1. Concentrate efforts to achieve acceptable consistency on one medical or surgical unit at a time. Work with that unit only until the goal of 90% consistency is reached; then move to the next unit.

2. The evaluating nurses should classify 15 patients on the nursing unit every day until 90% consistency is achieved. Consistency, in this instance, will mean that nurses on the unit are following the established procedure for classifying patients, and that there is agreement between the evaluating nurse and the unit nurses in the classification assigned to each patient.

3. The evaluating nurse should classify patients without prior consultation with nurses on the unit.

4. Corrective measures should be taken immediately after an evaluation when consistency is found to be less than 90%. This should be done in a helpful and instructive manner with nursing unit staff. Immediate feedback to the Head Nurse is recommended. The participation of the Head Nurse is essential in efforts to clarify points of confusion and to achieve greater consistency.

5. After a nursing unit has achieved 90% consistency, plan to evaluate it again at the end of one month to ensure that 90% consistency is maintained. If classification consistency falls below 90%, continue a more intensive review until problems are corrected.

6. When a nursing unit has maintained 90% consistency at the end-of-month review, plan to review the unit every three months thereafter.

7. Nursing units should not know in advance when a review is to be done.

Guidelines to Aid Reviewers

1. A data collection form should be prepared which contains 10 sample patient classification cards on an 8 1/2 x 11 sheet of paper.

2. Each nurse reviewer will be assigned to a specific unit. To maintain objectivity the reviewer should not be assigned to her/his own unit.

3. The reviewer will independently classify patients. This process may include:

--review of the nursing care plan
--review of the patient's chart
--direct patient observation

4. Continue until all 15 patients have been classified.

5. Compare patient classification results obtained through the independent review with the results of the same 15 patients classified by the unit. In reviewing the unit's classification results, it is important to check the accuracy and completeness of the classification cards done by the individual unit. This includes checks on addition and correct procedures in marking the card.

6. Identify inconsistencies between results of the classification done on the unit and the reviewer's results on the data collection form. Discuss these with the Head Nurse or Nurse in charge.

7. Provide further comments on the data collection sheet, as appropriate for each discrepancy, noting whether the variation is justified based on additional information or is considered to be unjustified.

8. Results should be entered on a summary report for each unit. A sample report illustrating the format is shown below.

Inter-Rater Reliability Summary Report
Medical/Surgical Patient Classification System

		Number of Classifications		Percentage
Unit	Date of Review	with agreement	without agreement	of consistency

Comments:

9. **Example:** 15 patients were reviewed and classified. There was inter-rater agreement on 12 patients. Therefore, the percentage of consistency was 12 divided by 15, which is 80%.

Results of the reviews provide a valuable management tool in directing educational and other resources to areas where problems may exist. This information also provides a method to determine the status of the implementation of the patient classification system and the reliability of the data within each Nursing Service.

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

Circular 10-84-103
July 6, 1984

TO: Regional Directors; Directors, All DM&S Field Activities

SUBJ: CLASSIFICATION OF EXTENDED CARE PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS (RCS 10-0624)

1. The purpose of this Circular is to provide instructions for health care facilities to classify extended care patients according to their nursing care needs. This methodology for Nursing Service is based on classification of patients according to their nursing care requirements, related to patient dependency and amount of direct nursing care provided. This patient classification methodology will be used on Intermediate Medicine and Nursing Home Care Units only.

2. The classification has been fully tested and validated. Instructions have been developed and effective application of the methodology will depend upon proper classification of the patient. A procedure to ensure inter-rater reliability should be utilized. (Refer to Circular 10-84-24, Attachment D)

3. The Nursing Service of each medical center will classify patients according to the attached criteria. Patients will be classified on Intermediate Medicine and Nursing Home Care Units each day. After familiarity with the classification system, this procedure will be accomplished in a matter of seconds. The classifier should be a registered nurse who knows the patient. A second registered nurse should periodically sample and evaluate the classification process.

4. The Automated Management Information System (AMIS) will continue to be used as the nursing service reporting mechanism. (Instructions for AMIS, MP-6, Part VI, Supplement No. 1.2, Change 170, November 8, 1979). A major difference from the present categorization is that Category I-II-III-IV will be reversed for Intermediate Medicine and Nursing Home Care Unit bed sections. For example Category I is minimal and Category III requires extensive/complete nursing care.

5. It is a requirement that the classification of each patient be verified at 3:00 P.M. every day by the head nurse or designee.

THIS CIRCULAR EXPIRES JULY 5, 1985

6. Intermediate Medicine and Nursing Home Care Unit patients will be classified using this system for the AMIS Report effective upon receipt of Circular. The title of this report is "Classification of Extended Care Patients According to their Nursing Care Needs" and RSC 10-0624 applies. Questions concerning this circular may be directed to Yvonne Moody in VACO (118), FTS 389-2065.

Arthur J Lewis MD
ARTHUR J. LEWIS, M.D.
Acting Deputy Chief Medical Director

Attachments

DISTRIBUTION: COB: (10) only
SS (118) FLD: DMSFA-5 each, RD-2 each plus 200-8
EX: Box 44-6, Boxes 104, 60, 54, 52-1 each & 63-5

July 6, 1984

CRITERIA FOR CLASSIFYING EXTENDED CARE PATIENTS ACCORDING TO NURSING CARE REQUIREMENTS

INSTRUCTION GUIDE

Criteria have been prepared to classify patients into one of three categories according to their individual nursing care needs. The categories range from minimal nursing care to (Category I) to extensive/complete nursing care (Category III).

PURPOSE OF CLASSIFICATION:

To determine the number of patients classified into each of three categories that represent requirements for nursing care and to serve as a measure for staffing intermediate medicine and nursing home care bed sections.

PROCEDURE FOR CLASSIFYING PATIENTS:

1. VA Form 10-0005a, Patient Classification Card, will be used for each patient. This classification card will be imprinted with the patient identification information and placed in the Nursing Care Plan (such as Kardex).
2. Newly admitted patients will be classified upon admission.
3. Each registered nurse will classify assigned patients daily.
4. The category of each patient will be verified at 3:00 p.m. every day by the head nurse or designee.
5. Data should be reported according to AMIS instructions.

GENERAL INSTRUCTIONS:

1. Using the attached definitions and instructions, the patient will be placed in the category which best identifies individual nursing care needs.
2. Sufficient information is provided in this Circular for the use of the classification instrument.

Attachment B

Circular 10-84-103
July 6, 1984

Definitions and Instructions

Special Guidelines for Extended Care Patient Classification

Areas Indicating Needs for Care	Instructions Check appropriate indicator of care.
1. Basic Hygiene/Bathing	
Self	Patient needs no help or supervision.
Partial Assist	Patient can start own bath but not complete it. May need help to get into shower or tub, supervision or encouragement during bath, or assistance to dress.
Complete Assist	Must be bathed, showered and dressed (does not participate).
2. Nutrition/Feeding	
Self	Patient needs no help or supervision.
Partial Assist	Can feed self after cartons are opened and food is cut. May require supervision and encouragement to eat.
Complete Assist	Must be fed totally by another person; or may need constant supervision and encouragement due to swallowing difficulties, resistiveness. Include gastric gavage; tube feedings.
3. Elimination	
Self	Patient is continent and does not have accidents or takes care of ostomy, catheter, or related device by self.
Assist	Requires assistance with bedpan or urinal; or receives help in care of ostomy, catheter or related device. May include a scheduled bowel or bladder program.
Incontinent	Has inadequate control of bladder or bowels (regardless of staff intervention) requiring complete assistance/ incontinent care at least once per shift.
4. Mobility	
Self	Patient transfers, walks or wheels self without assistance or supervision.

Partial Assist	Needs some assistance or supervision in transferring, walking or wheeling.
Complete Assist	Needs complete assistance (does not participate) in transferring; is wheeled or bed confined. Requires help in positioning and maintaining proper alignment (i.e., traction, footboards).
5. Behavior/Orientation	
Alert, Oriented, Responsive	Patient is oriented to time, place, person. No disruptive behavior problems.
Occasionally Disoriented, Confused	Disoriented in one or two spheres (time, place, person); may have alternative periods of awareness/unawareness; may exhibit some disruptive behavior, i.e., disrobing, screaming, wandering into unacceptable places.
Disoriented, Combative, Unresponsive	Is disoriented in all three spheres (time, place, person), or is unresponsive or exhibits resistive, striking out, or aggressive behavior to a degree that there is impairment in the performance of basic activities of daily living.

Item Entries	Check one item that best describes the patient's care needs in each of the five major areas: basic hygiene, nutrition, elimination, mobility and behavior. Only one item should be checked for each major care area. For example, if in the area of basic hygiene, a patient needs to be bathed completely by nursing staff "complete assist" is checked.
Totals	The number of checks in each column are added vertically and then entered in the row marked "total" under the appropriate column. The column with the greatest number of checks is the patient's classfication.
Circle the Category	The appropriate category should be circled at the bottom of the form. If there is a tie, the higher category is circled.

Attachment C

Circular 10-84-103
July 6, 1984

The following are examples of the Extended Care Patient Classification form (VAF 10-0005a). Category I consists of minimal care patients; Category II, moderate care patients; Category III, extensive or complete care patients.

The patient's name, bed number, unit and date are entered at the top of the form.

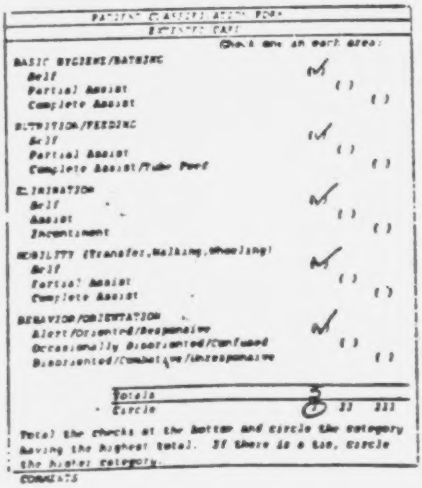
To classify an extended care patient, check one item that best describes the patient's care needs in each of the five major areas: basic hygiene/bathing, nutrition/feeding, elimination, mobility, and behavior/orientation.

For example, if in the area of basic hygiene a patient can bathe independently, "self" is checked; whereas another patient who needs to be bathed completely by nursing staff is checked as "complete assist."

Please note that only one item should be checked for each major care area.

The number of checks in each column are added vertically and then entered in the row marked "total" under the appropriate column. The column with the greatest number of checks is the patient's classification. The category should be circled at the bottom of the form. If there is a tie, the higher category is circled.

NURSING
PATIENT CLASSIFICATION FORM



PATIENT CLASSIFICATION FORM
EXTENDED CARE

Check one in each area:

BASIC HYGIENE/BATHING			
Self	(✓)		
Partial Assist		( )	
Complete Assist			( )
NUTRITION/FEEDING			
Self	(✓)		
Partial Assist		( )	
Complete Assist/Tube Feed			( )
ELIMINATION			
Self	(✓)		
Assist		( )	
Incontinent			( )
MOBILITY (Transfer,Walking,Wheeling)			
Self	(✓)		
Partial Assist		( )	
Complete Assist			( )
BEHAVIOR/ORIENTATION			
Alert/Oriented/Responsive	(✓)		
Occasionally Disoriented/Confused		( )	
Disoriented/Combative/Unresponsive			( )
Totals	5		
Circle	[✓ I]	II	III

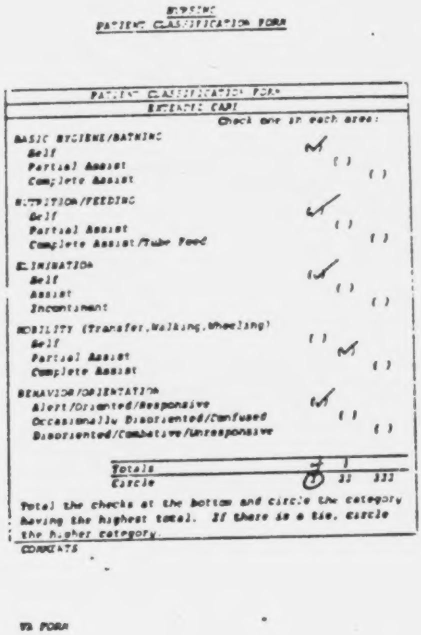
Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the higher category.

COMMENTS

VA FORM

Patient Classification I (Example)

B.H. is a 58 year old male diagnosed one year ago with Parkinson's Disease. Mr. H. is alert, oriented and able to carry out activities of daily living. Supervision is necessary when ambulating due to instability of gait. Mr. H. is on a 2 Gm. sodium diet for Mild Hypertension and is able to feed himself. He is scheduled for occupational therapy three times per week. He is currently undergoing drug therapy to determine maintenance dosage.



NURSING
PATIENT CLASSIFICATION FORM

PATIENT CLASSIFICATION FORM
EXTENDED CARE

	Check one in each area:		
BASIC HYGIENE/BATHING			
Self	✓		
Partial Assist		( )	
Complete Assist			( )
NUTRITION/FEEDING			
Self	✓		
Partial Assist		( )	
Complete Assist/Tube Feed			( )
ELIMINATION			
Self	(✓		
Assist		( )	
Incontinent			( )
MOBILITY (Transfer, Walking, Wheeling)			
Self	( )		
Partial Assist		✓	
Complete Assist			( )
BEHAVIOR/ORIENTATION			
Alert/Oriented/Responsive	✓		
Occasionally Disoriented/Confused		( )	
Disoriented/Combative/Unresponsive			( )
Totals	4	1	
Circle	[✓ I]	II	III

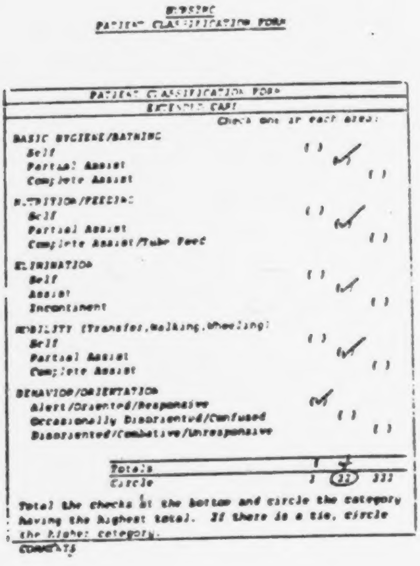
Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the higher category.

COMMENTS

VA FORM

Patient Classification II (Example)

B.G. is an 80 year old male with Post Partial Bowel Resection two months ago and a secondary diagnosis of Degenerative Joint Disease. Bowel sounds are present and he tolerates his regular diet well. Due to limited ROM, he needs assistance with setting up his food tray, bathing and dressing. Mr. G. ambulates with a walker and maintains bathroom privileges with assistance. He ambulates TID, is up in a chair for one hour TID, and has VS q8h.



NURSING
PATIENT CLASSIFICATION FORM

PATIENT CLASSIFICATION FORM
EXTENDED CARE

Check one in each area:

BASIC HYGIENE/BATHING
- Self ☐
- Partial Assist ☑
- Complete Assist ☐

NUTRITION/FEEDING
- Self ☐
- Partial Assist ☑
- Complete Assist/Tube Feed ☐

ELIMINATION
- Self ☐
- Assist ☑
- Incontinent ☐

MOBILITY (Transfer, Walking, Wheeling)
- Self ☐
- Partial Assist ☑
- Complete Assist ☐

BEHAVIOR/ORIENTATION
- Alert/Oriented/Responsive ☑
- Occasionally Disoriented/Confused ☐
- Disoriented/Combative/Unresponsive ☐

	I	II	III
Totals	1	4	
Circle	I	[✓ II]	III

Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the higher category.

COMMENTS

VA FORM

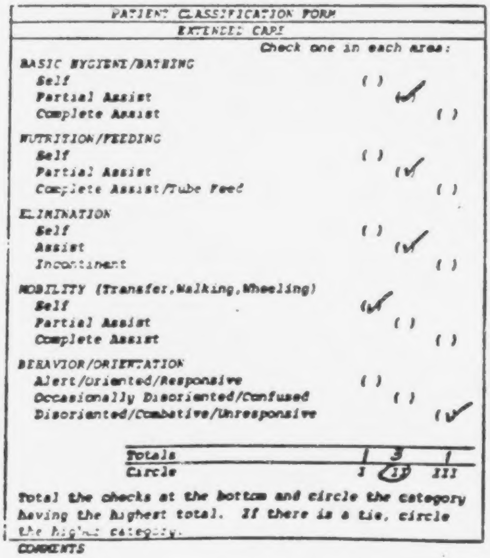
Circular 10-84-103

July 6, 1984

Patient Classification II (Example)

J.B., a 66 year old male, was transferred to the NHC Unit with diagnoses of Alzheimer's Disease, Benign Prostatic Hypertrophy and C.O.P.D. Mr. B. is disoriented x 3 and requires continuous reality orientation. He has episodes of nocturnal combativeness which often require use of soft restraints. Mr. B. is able to bathe and feed himself with direction and supervision. He has a foley catheter for urinary retention. He walks without assistance, but he must be escorted when leaving the unit.

NURSING
PATIENT CLASSIFICATION FORM



PATIENT CLASSIFICATION FORM

EXTENDED CARE

	Check one in each area:		
BASIC HYGIENE/BATHING			
Self	( )		
Partial Assist		(✓)	
Complete Assist			( )
NUTRITION/FEEDING			
Self	( )		
Partial Assist		(✓)	
Complete Assist/Tube Feed			( )
ELIMINATION			
Self	( )		
Assist		(✓)	
Incontinent			( )
MOBILITY (Transfer, Walking, Wheeling)			
Self	(✓)		
Partial Assist		( )	
Complete Assist			( )
BEHAVIOR/ORIENTATION			
Alert/Oriented/Responsive	( )		
Occasionally Disoriented/Confused		( )	
Disoriented/Combative/Unresponsive			(✓)
Totals	1	3	1
Circle	I	[✓ II]	III

Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the higher category.

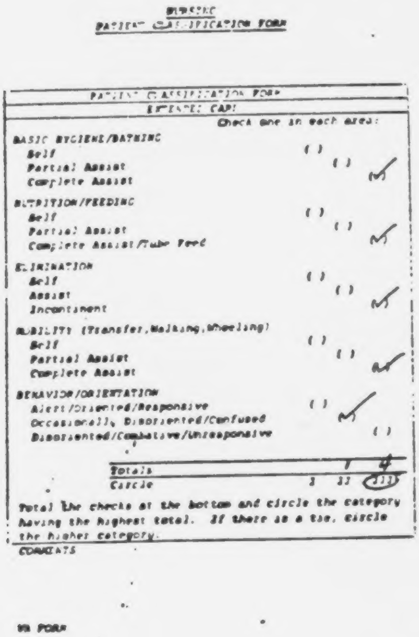
COMMENTS

VA FORM

Circular 10-84-103
July 6, 1984

Patient Classification III (Example)

I.C. is a 65 year old female admitted with a CVA that occurred two years ago. Her family is no longer able to care for her. Mrs. C. has Residual Rt. Hemiparesis, Dysphagia and Global Aphasia. She requires complete assistance in hygiene, eating, mobility and elimination. Mrs. C. tolerates her diet well. Head of bed is to be elevated 30 degrees during the day and evening. Foley catheter is present and footboard is applied to the bed. She requires skilled care and repositioning q2h. She is up in chair BID for 30 minutes. She experiences transient disorientation.



NURSING
PATIENT CLASSIFICATION FORM

PATIENT CLASSIFICATION FORM
EXTENDED CARE

Check one in each area:

BASIC HYGIENE/BATHING			
Self	( )		
Partial Assist		( )	
Complete Assist			✓
NUTRITION/FEEDING			
Self	( )		
Partial Assist		( )	
Complete Assist/Tube Feed			✓
ELIMINATION			
Self	( )		
Assist		( )	
Incontinent			✓
MOBILITY (Transfer, Walking, Wheeling)			
Self	( )		
Partial Assist		( )	
Complete Assist			✓
BEHAVIOR/ORIENTATION			
Alert/Oriented/Responsive	( )		
Occasionally Disoriented/Confused		✓	
Disoriented/Combative/Unresponsive			( )
Totals		1	4
Circle	I	II	[✓ III]

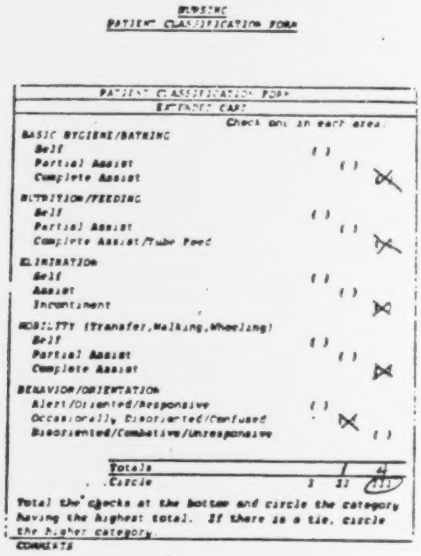
Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the higher category.

COMMENTS

VA FORM

Patient Classification III (Example)

Ms. M. is a 72 year old female admitted for a Rt. Pelvic Fracture which occurred four months ago. She was transferred from the surgical unit. Secondary diagnoses include insulin controlled Diabetes Mellitus, Hypertension and Arthritis. She is blind and has some loss of hearing. She is edentulous, and cannot tolerate oral intake. Continual enteral nutrition support via Keofeed tube is needed to prevent further weight loss. Due to pelvic immobilization, arthritis and generalized weakness, Ms. M. requires complete assistance with ADLs. She experiences transient disorientation at night which requires placement of protective devices.



NURSING
PATIENT CLASSIFICATION FORM

PATIENT CLASSIFICATION FORM
EXTENDED CARE

	Check one in each area.		
BASIC HYGIENE/BATHING			
Self	( )		
Partial Assist		( )	
Complete Assist			☒
NUTRITION/FEEDING			
Self	( )		
Partial Assist		( )	
Complete Assist/Tube Feed			☒
ELIMINATION			
Self	( )		
Assist		( )	
Incontinent			☒
MOBILITY (Transfer, Walking, Wheeling)			
Self	( )		
Partial Assist		( )	
Complete Assist			☒
BEHAVIOR/ORIENTATION			
Alert/Oriented/Responsive	( )		
Occasionally Disoriented/Confused		☒	
Disoriented/Combative/Unresponsive			( )
Totals		1	4
Circle	I	II	[✓ III]

Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the higher category.

COMMENTS

VA FORM

NURSING
PATIENT CLASSIFICATION FORM

PATIENT CLASSIFICATION FORM			
EXTENDED CARE			
	Check one in each area:		
BASIC HYGIENE/BATHING			
Self	( )		
Partial Assist		( )	
Complete Assist			( )
NUTRITION/FEEDING			
Self	( )		
Partial Assist		( )	
Complete Assist/Tube Feed			( )
ELIMINATION			
Self	( )		
Assist		( )	
Incontinent			( )
MOBILITY (Transfer,Walking,Wheeling)			
Self	( )		
Partial Assist		( )	
Complete Assist			( )
BEHAVIOR/ORIENTATION			
Alert/Oriented/Responsive	( )		
Occasionally Disoriented/Confused		( )	
Disoriented/Combative/Unresponsive			( )
Totals			
Circle	I	II	III

Total the checks at the bottom and circle the category having the highest total. If there is a tie, circle the highest category

COMMENTS

VA FORM 10-0005a
June 1984

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

Circular 10-85- 164

October 24, 1985

TO: Regional Directors; Directors, All DM&S Field Activities

SUBJ: CLASSIFICATION OF PSYCHIATRIC PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS (RCS- 10-0034))

1. The purpose of this Circular is to provide instructions for health care facilities to classify psychiatric patients according to their nursing care needs. This methodology for Nursing Service is based on classification of patients according to their nursing care requirements, related to patient dependency and amount of direct nursing care provided. This patient classification methodology will be used on Psychiatric Nursing Units only (Drug and Alcohol Units are excluded).

2. The classification has been fully tested and validated. Instructions have been developed and effective application of the methodology will depend upon proper classification of the patient. A procedure to ensure inter-rater reliability should be utilized (Refer to Circular Attachment D).

3. The Nursing Service of each medical center will classify patients according to the attached criteria. Patients will be classified on Psychiatric Nursing Units each day. After familiarity with the classification system, this procedure will be accomplished in a matter of seconds. The classifier should be a registered nurse who knows the patient. A second registered nurse should periodically sample and evaluate the classification process.

4. The Automated Management Information System (AMIS) will continue to be used as the nursing service reporting mechanism. (Instructions for AMIS, MP-6, Part VI, Chapter 2, Change 170, dated November 8, 1979 and change 216 dated January 2, 1985). A major difference from the present categorization is that Category I-II-III-IV will be reversed for Psychiatric bed sections. For example, Category I is minimal and Category IV requires extensive/complete nursing care.

5. It is a requirement that the classification of each patient be verified at 3:00 P.M. every day by the Head Nurse or designee.

6. Psychiatric patients will be classified using this system for the AMIS Report effective upon receipt of Circular. The title of this report is "Classification of Psychiatric Patients According to their Nursing Care Needs" and RCS- 10-0034 applies. Questions concerning this circular may be directed to Yvonne Moody in VACO (118), FTS 389-3527.

[illegible]

John A Gronvall, M.D.
JOHN A GRONVALL, M.D.
Deputy Chief Medical Director

Attachments

DISTRIBUTION: COA: (10) only
SS (118H) FLD: DMSFA-1 each; RD-1 each plus 200-2
EX: Boxes 44-6 & 88-2, Boxes 104, 60, 54, 52-1 each & 63-5

THIS CIRCULAR EXPIRES ON OCTOBER 23, 1986

CRITERIA FOR CLASSIFYING PSYCHIATRIC PATIENTS ACCORDING TO NURSING CARE REQUIREMENTS

INSTRUCTION GUIDE

Criteria have been prepared to classify patients into one of four categories according to their individual nursing care needs. The categories range from minimal nursing care (Category I) to extensive/complete nursing care (Category IV).

PURPOSE OF CLASSIFICATION.

To determine the number of patients classified into each of four categories that represent requirements for nursing care and to serve as a measure for staffing psychiatric bed sections.

GENERAL INSTRUCTIONS FOR CLASSIFYING PATIENTS

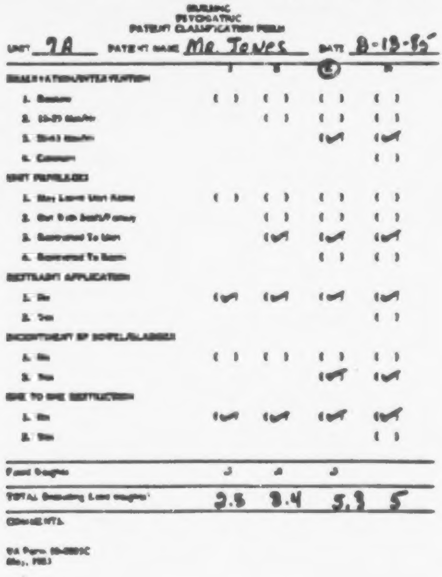
1. VA Form 10-0005C Patient Classification Card, will be used for each patient. This classification card will be imprinted with the patient identification information and placed in the Nursing Care Plan (such as Kardex).
2. Using the attached definitions and instructions, the patient will be placed in the category which best identifies individual nursing care needs.
3. Newly admitted patients will be classified upon admission.
4. Each registered nurse will classify assigned patients daily.
5. The category of each patient will be verified at 3:00 p.m. every day by the Head Nurse or designee.
6. Data should be reported according to AMIS instructions.

CIRCULAR 10-85-164
October 24, 1985

COMPLETING THE PATIENT CLASSIFICATION FORM

The following are examples of the Psychiatric Patient Classification form (VAF 10-0005c). Categories range from category I, Minimal Care to category IV, Extensive Nursing Care.

1. Enter patient identification information, unit, and date at top of form.
2. Mark patient care indicators by entering checks in parentheses on appropriate lines. If the line has multiple parentheses, check them all.
3. Check the indicator that best describes the patients care needs in each of the five major areas: Observation/Intervention; Unit Privileges; Restraints; Incontinent of Bowel/Bladder; One to One Restriction. Only one indicator should be checked for each major care area. For example: Unit Privileges - If a patient may leave the unit alone, only this indicator should be checked. When checking an indicator all brackets ( ) must be checked horizontally for that indicator.
4. Total the number of checks in each column and enter the totals on the appropriate lines. Always include the FIXED WEIGHT count in Categories I, II, and III.
5. The column with the highest total determines the patient's category. The appropriate category number at the top of the column is circled.
6. Use the "Comments" space to record a special situation which justifies a higher category than indicated by the total. For example, a patient requiring complex dressings.



NURSING
PSYCHIATRIC
PATIENT CLASSIFICATION FORM

UNIT 7A PATIENT NAME Mr. Jones DATE 8-13-85

	I	II	[✓ III]	IV
OBSERVATION/INTERVENTION				
1. Routine	( )	( )	( )	( )
2. [illegible]		( )	( )	( )
3. [illegible]			(✓)	(✓)
4. Constant				( )
UNIT PRIVILEGES				
1. May Leave Unit Alone	( )	( )	( )	( )
2. Out With Staff/Family		( )	( )	( )
3. Restricted To Unit		(✓)	(✓)	(✓)
4. Restricted To Room			( )	( )
RESTRAINT APPLICATION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
INCONTINENT OF BOWEL/BLADDER				
1. No	( )	( )	( )	( )
2. Yes			(✓)	(✓)
ONE TO ONE RESTRICTION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
Fixed Weights	[illegible]	[illegible]	[illegible]	
TOTAL [illegible]	2.5	3.4	5.3	5

COMMENTS:

VA Form 10-0005C
[illegible]

ATTACHMENT B

CIRCULAR 10-85-164
October 24, 1985

DEFINITIONS AND INSTRUCTIONS

Special Guidelines for Psychiatric Classification

Areas Indicating Needs for Care	Definitions
	(Check appropriate indicator of care.)
OBSERVATION/INTERVENTION	
1. Routine	Requires observation of specific symptoms or conditions that would require nursing to observe patient over and above routine rounds. Includes vital signs, neuro checks, color, patient orientation and/or combativeness. The appropriate criteria should be checked according to the time listed. Also included in the criterion is the amount of time required on an interpersonal level.
2. 15-25 Min/Hr.	
3. 30-45 Min/Hr.	
4. Constant	
UNIT PRIVILEGES	
1. May leave unit alone	Check, if patient has a pass or permission to leave unit unaccompanied.
2. Out with staff/family	Check, if patient has off unit privileges with family, staff members or others.
3. Restricted to unit	Check, if patient has no pass or is not allowed off unit to attend groups.
4. Restricted to room	Check, if patient is restricted to room or is in seclusion.
RESTRAINT APPLICATION	
1. No	Check yes, for patient who requires application of leather/plastic restraints. Check no, if it does not apply.
2. Yes	
INCONTINENT OF BOWEL/BLADDER	
1. No	Check yes, for patient who is actively incontinent of urine or feces. Also applies to patients with extreme diaphoresis. Does not need to be marked if patient has indwelling catheter. Check no, if it does not apply.
2. Yes	
ONE TO ONE RESTRICTION	
1. No	Check yes, if patient requires constant nursing supervision during the entire shift, (e.g. suicide precautions). Check no, if it does not apply.
2. Yes	

Item Entries (Indicators) and weighting factors	Check the indicator that best describes the patients care needs in each of the five major areas: Observation/Intervention; Unit Privileges; Restraints; Incontinent of Bowel/Bladder; One to One Restriction. Only one indicator should be checked for each major care area. For example: Unit Privileges-If a patient may leave the unit alone, only this indicator should be checked. When checking an indicator all brackets ( ) must be checked horizontally for that indicator.
Fixed Weights:	Pre-existing weights in columns I, II, III should be counted when adding columns.
Totals:	When all the indicators of care are checked. The checks in each column are added vertically plus the pre-existing weight in column 1,2,3 and the total is put in the space for total.
Circle the Category	The column with the highest added number will be the patient's category. Circle the category at the top of the column.
Comments:	Use this space to record special situations which may warrant a higher classification than is circled. For example, a patient requiring complex dressings.

ATTACHMENT C

CIRCULAR 10-85-164
October 24, 1985

The following are examples of the Psychiatric Patient Classification form (VAF 10-0005C). Categories range from Category I, minimal care to Category IV, extensive nursing care.

The patient's name, unit and date are placed at the top of the card.

To classify a psychiatric patient, one indicator in each major care area should be checked.

Please note that if an indicator is checked all brackets horizontally must be checked.

The number of checks in each column are added vertically with the pre-existing fixed weight and then placed in the Total's area under the appropriate column.

The column with the highest total is the patient's category. The category should be circled at the top of the appropriate column.

EXAMPLE: PATIENT CATEGORY I

Mr J., 47 years old, was admitted two weeks ago with Post Traumatic Stress Disorder. He has been attending group therapy on a daily basis. He needs minimal supervision from the nursing staff and is motivated to follow his treatment plan. He is involved with Social Service for job re-training and placement.

NURSING
PSYCHIATRIC
PATIENT CLASSIFICATION

Patient ID NO. 336-34-1746 Unit: 6/A
Name Mr. J Date: 3/13/85

PATIENT CARE INDICATORS	CATEGORIES			
	[✓ I]	II	III	IV
OBSERVATION/INTERVENTION				
1. Routine	(✓)	(✓)	(✓)	(✓)
2. 15-25 Min/Hr		( )	( )	( )
3. 30-45 Min/Hr			( )	( )
4. Constant				( )
UNIT PRIVILEGES				
1. May Leave Unit Alone	(✓)	(✓)	(✓)	(✓)
2. Out With Staff/Family		( )	( )	( )
3. Restricted To Unit		( )	( )	( )
4. Restricted To Room			( )	( )
RESTRAINT APPLICATION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
INCONTINENT OF BOWEL/BLADDER				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes			( )	( )
ONE TO ONE RESTRICTION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
Fixed Weights	.5	.4	.3	
TOTAL (Including fixed weights)	5.5	5.4	5.3	5

COMMENTS:

VA Form 10-0005c
May 1985

EXAMPLE: PATIENT CATEGORY II

Mr. P. is a 52 year old who was admitted with a diagnosis of Undifferentiated Schizophrenia. He is hospitalized for medication re-evaluation. He attends unit activities and is fairly cooperative. At times he is delusional in his conversion with peers and staff. He is only allowed to go off the unit with a staff member or his family.

NURSING
PSYCHIATRIC
PATIENT CLASSIFICATION

Patient ID NO. 336-35-1846 Unit: 6A
Name Mr. P. Date: 3-13-85

PATIENT CARE INDICATORS	CATEGORIES			
OBSERVATION/INTERVENTION	I	[✓ II]	III	IV
1. Routine	(✓)	(✓)	(✓)	(✓)
2. 15-25 Min/Hr		( )	( )	( )
3. 30-45 Min/Hr			( )	( )
4. Constant				( )
UNIT PRIVILEGES				
1. May Leave Unit Alone	( )	( )	( )	( )
2. Out With Staff/Family		(✓)	(✓)	(✓)
3. Restricted To Unit		( )	( )	( )
4. Restricted To Room			( )	( )
RESTRAINT APPLICATION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
INCONTINENT OF BOWEL/BLADDER				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes			( )	( )
ONE TO ONE RESTRICTION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
Fixed Weights	.5	.4	.3	
TOTAL (Including fixed weights)	4.5	5.4	5.3	5

COMMENTS:

VA Form 10-0005c
May 1985

EXAMPLE: PATIENT CATEGORY III

Mr. S. was admitted two days ago with a diagnosis of Alzheimer's Disease. He is disoriented x3. He requires complete assistence with ADL'S and is incontinent of urine. Nursing staff interact frequently with Mr. S. for reality orientation. He is restricted to the unit as he wanders and gets lost.

NURSING
PSYCHIATRIC
PATIENT CLASSIFICATION

Patient ID NO. 397- 47 - 8646 Unit: 6A
Name MR. S. Date: 3-13-85

PATIENT CARE INDICATORS	CATEGORIES			
OBSERVATION/INTERVENTION	I	II	[✓ III]	IV
1. Routine	( )	( )	( )	( )
2. 15-25 Min/Hr		(✓)	(✓)	(✓)
3. 30-45 Min/Hr			( )	( )
4. Constant				( )
UNIT PRIVILEGES				
1. May Leave Unit Alone	( )	( )	( )	( )
2. Out With Staff/Family		( )	( )	( )
3. Restricted To Unit		(✓)	(✓)	(✓)
4. Restricted To Room			( )	( )
RESTRAINT APPLICATION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
INCONTINENT OF BOWEL/BLADDER				
1. No	( )	( )	( )	( )
2. Yes			(✓)	(✓)
ONE TO ONE RESTRICTION				
1. No	(✓)	(✓)	(✓)	(✓)
2. Yes				( )
Fixed Weights	.5	.4	.3	
TOTAL (Including fixed weights)	2.5	4.4	5.3	5

COMMENTS:

VA Form 10-0005c
May 1985

EXAMPLE: PATIENT CATEGORY IV

Mrs. B. is a 28 year old admitted two days ago with a diagnosis of Acute Depression. She refuses to eat, is unable to sleep, and paces constantly. She refuses to socialize with other people on the unit. She was placed on one to one restriction because she slashed her wrist last night and she continues to express serious suicidal ideation.

NURSING
PSYCHIATRIC
PATIENT CLASSIFICATION

Patient ID NO, 338-48-1686 Unit: 6A
Name Mrs. B Date: 8-13-85

PATIENT CARE INDICATORS	CATEGORIES			
OBSERVATION/INTERVENTION	I	II	III	[✓ IV]
1. Routine	☐	☐	☐	☐
2. 15-25 Min/Hr		☐	☐	☐
3. 30-45 Min/Hr			☐	☐
4. Constant				☑
UNIT PRIVILEGES				
1. May Leave Unit Alone	☐	☐	☐	☐
2. Out With Staff/Family		☐	☐	☐
3. Restricted To Unit		☑	☑	☑
4. Restricted To Room			☐	☐
RESTRAINT APPLICATION				
1. No	☑	☑	☑	☑
2. Yes				☐
INCONTINENT OF BOWEL/BLADDER				
1. No	☑	☑	☑	☑
2. Yes			☐	☐
ONE TO ONE RESTRICTION				
1. No	☐	☐	☐	☐
2. Yes				☑
Fixed Weights	.5	.4	.3	
TOTAL (Including fixed weights)	2.5	3.4	3.3	5

COMMENTS:

VA Form 10-0005c
May 1985

Attachment D

CIRCULAR 10-85-164
October 24, 1985

SUGGESTED PROCEDURE TO ENSURE INTER-RATER RELIABILITY AMONG NURSES IN CLASSIFYING PSYCHIATRIC PATIENTS

Why is Inter-rater Reliability Important?

The determination of workload and nurse staffing requirements are dependent on accurate classification of patients. Inter-rater reliability is a method to establish and maintain consistency in the way nurses classify patients both within an individual nursing unit and among all similar units at each hospital.

In order to check on the internal consistency of the patient classification system, an evaluation of inter-rater reliability must be conducted. Since accurate assessments of patient classification are an integral component in the determination of required nursing hours, the reliability of the patient classification process should be evaluated periodically and corrective measures should be taken when indicated as part of an ongoing program.

Purpose and Scope

The purpose of this procedure is to measure and minimize variability in the way different nurse raters classify the same kinds of patients using the current psychiatric patient classification system. The procedure is directed at achieving a high level of consistency in patient classification or inter-rater reliability within a health care facility. Efforts to measure and attain high inter-rater reliability among different hospitals within the VA health care system may be taken at a later date.

Who Should Perform this Function?

The success of the patient classification system and the evaluation of inter-rater reliability is dependent upon knowledge of the system and a commitment to it by each nurse who is involved. A registered nurse, designated by the Chief, Nursing Service, should be assigned the overall responsibility to evaluate levels of inter-rater reliability. The nurse assigned this responsibility may be in either a staff role or a management position. This determination should be based on the organizational structure of the Nursing Service and availability of resources. Nurses who should be considered are Nursing Instructors, Clinical Nurse Specialists, Nursing Supervisors, and Head Nurses.

Two additional nurses, designated by the Chief, Nursing Service, should be assigned to assist the nurse who is responsible for this project. Assistants should have a thorough knowledge and demonstrate competence in the nursing care requirements of psychiatric patients and the patient classification system.

Process

This approach is based on evaluating the consistency of patient classification among nurses, and working with individual nursing units until acceptable levels of consistency are achieved. A reduced frequency of review is then performed to ensure continued high levels of reliable patient classification.

The proposed frequency and scope for evaluating consistency is outlined below:

1. Concentrate efforts to achieve acceptable consistency on one psychiatric unit at a time. Work with that unit only until the goal of 90% consistency is reached, then move to the next unit.

2. The evaluating nurses should classify 15 patients on the nursing unit every day until 90% consistency is achieved. Consistency, in this instance, will mean that nurses on the unit are following the established procedure for classifying patients, and that there is agreement between the evaluating nurse and the unit nurses in classification assigned to each patient.

3. The evaluating nurse should classify patients without prior consultation with nurses on the unit.

4. Corrective measures should be taken immediately after an evaluation when consistency is found to be less than 90%. This should be done in a helpful and instructive manner with the nursing unit staff. Immediate feedback to the Head Nurse is recommended. The participation of the Head Nurse is essential in efforts to clarify points of confusion and to achieve greater consistency.

5. After a unit has achieved 90% consistency, plan to evaluate it again at the end of one month to ensure that 90% consistency is maintained. If classification consistency falls below 90%, continue a more intensive review until problems are corrected.

6. When a nursing unit has maintained 90% consistency at the end-of-month review, plan to review the unit every three months thereafter.

7. Nursing should not know in advance when a review is to be performed.

Guidelines to Aid Reviewer

1. A data collection form should be prepared which contains 10 sample patient classification cards on an 8½ x 11 sheet of paper.

2. Each nurse reviewer will be assigned to a specific unit. To maintain objectivity the reviewer should not be assigned to her/his own unit.

3. The reviewer will independently classify patients. This process may include:

— review of the nursing care plan
— review of the patient's chart
— direct patient observation

4. Continue until all 15 patients have been classified.

5. Compare patient classification results obtained through the independent review with the results of the same 15 patients classified by the unit. In reviewing the unit's classification results, it is important to check the accuracy and completeness of the classification cards done by the individual unit. This includes checks on addition and correct procedures in marking the card.

6. Identify inconsistencies between results of the classification done on the unit and the reviewer's results on the data collection form. Discuss these with the Head Nurse or Nurse in Charge.

7. Provide further comments on the data collection sheet, as appropriate for each discrepancy, noting whether the variation is justified based on additional information or is considered to be unjustified.

8. Results should be entered on a summary report for each unit. A sample report illustrating the format is shown below.

Inter-Rater Reliability Summary Report
Psychiatric Patient Classification System

		Number of Classifications		Percentage
Unit	Date of Review	with agreement	without agreement	of consistency

Comments:

9. Example: 15 patients were reviewed and classified. There was inter-rater agreement on 12 patients. Therefore, the percentage of consistency was 12 divided by 15, which is 80%.

Results of the reviews provide a valuable management tool in directing educational and other resources to areas where problems may exist. This information also provides a method to determine the status of the implementation of the patient classification system and the reliability of the data within each Nursing Service.

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420

Circular 10-85-82
May 14, 1985

TO: Regional Directors; Directors, All DM&S Field Activities

SUBJ: Classification of Critical Care Patients According to Their Nursing Care Needs

1. The purpose of this Circular is to provide instructions for health care facilities to classify critical care patients according to their nursing care needs. This methodology for Nursing Service is based on classification of patients according to their nursing care requirements, related to patient dependency and amount of direct nursing care provided. This patient classification methodology will be used on Critical Care Units only. Critical Care Units are defined as Medical Intensive Care Units, Surgical Intensive Care Units, Coronary Care Units, and combinations of these units. All other types of units are excluded. Specifically excluded are "step-down" and telemetry units.

2. The classification form (VA Form 10-0005b) has been fully tested and validated. An initial distribution of these forms will be made shortly. Instructions have been developed and effective application of the methodology will depend upon proper classification of the patient. A procedure to ensure inter-rater reliability should be utilized (Refer to Attachment D).

3. The Nursing Service of each medical center will classify patients according to the attached criteria. Patients will be classified on Critical Care Units each day. After familiarity with the classification system, the procedure will be accomplished in a matter of seconds. The classifier should be a registered nurse who knows the patient. A second registered nurse should periodically sample and evaluate the classification process.

4. It is a requirement that the classification of each patient be verified at 3:00p.m. every day by the head nurse or designee.

5. Questions concerning this circular may be directed to Yvonne Moody in VACO (118), FTS 389-3527.

John A Gronvall, M.D.
JOHN A. GRONVALL, M.D.
Deputy Chief Medical Director

Attachments

Distribution: COA: (10) only
SS (118) FLD: DMSFA-1 each; RD-1 each plus 200-2
EX: Boxes 44-6, Boxes 104, 60, 54, 52-1 each & 63-5

THIS CIRCULAR EXPIRES ON MAY 13, 1986

INSTRUCTIONS FOR CLASSIFYING CRITICAL CARE PATIENTS ACCORDING TO NURSING CARE REQUIREMENTS

INSTRUCTION GUIDE

Criteria have been prepared to classify patients into one of three categories according to their individual nursing care needs. The categories range from minimal nursing care (Category I) to extensive/complete nursing care (Category III).

PURPOSE OF CLASSIFICATION:

To determine the number of patients classified into each of three categories that represent requirements for nursing care and to serve as a measure for staffing critical care units.

GENERAL INSTRUCTIONS FOR CLASSIFYING PATIENTS:

1. VA Form 10-0005b, Patient Classification Card, will be used for each patient. This classification card will be completed and placed in the Nursing Care Plan (such as Kardex).
2. Using the attached definitions and instructions, the patient will be placed in the category which best identifies individual nursing care needs.
3. Newly admitted patients will be classified on admission.
4. Each registered nurse will classify assigned patients daily.
5. The category of each patient will be verified at 3:00p.m. every day by the head nurse or designee.
6. Data should be maintained locally until AMIS is revised to accommodate classification of critical care patients.

Attachment B

Circular 10-85-82
May 14, 1985

DEFINITIONS AND INSTRUCTIONS

Special Guidelines for Critical Care Patient Classification

Areas Indicating Needs for Care	Definitions
1. POSITION	
Partial Assist	Independent or needs partial assistance with ADL, coughing and deep breathing.
Complete Assist	Needs complete assistance with ADL and positioning, ROM, thermia units, special frames, circle beds, etc.
2. PHYSIOLOGICAL MONITORING	
At intervals of: More than 2 hours 1 to 2 hours 1 hour or less	Observation of body functions (temperature, blood pressure, heart function, etc.) including use of procedures or apparatuses for detecting and preventing problems.
3. INTRAVENOUS THERAPY	
IV	TKO; maintenance, Heparin lock; additive q4-6h.
IV - 2 or more lines (hemodynamic monitoring)	Multiple intravenous additives; blood; hyperalimentation; hemodynamic/pressure monitoring.
4. RESPIRATORY STATUS	
Non-Acute	Oxygen therapy; few changes with ventilator settings; arterial lines; ventilator dependent; pulmonary toilet q4-8h; treatments q4h.
Acute	Weaning; frequent pulmonary toilet (q1-2h); frequent endotracheal suctioning; unstable respiratory status; intubation; frequent ventilator changes.
5. SPECIAL PROCEDURES	These patients may require a 2:1 staff/patient ratio. May include such procedures as Blakemore tubes, cardioversion, insertion of pacemakers, intracranial pressure monitoring, extensive burn care, pericardiocentesis, circulatory or respiratory arrest, intra-aortic balloon pump, peritoneal dialysis, hemodialysis. A check on this line is automatically a Category III.

COMPLETING THE PATIENT CLASSIFICATION FORM

1. Enter patient identification information, unit, and date at top of form.

2. Mark patient care indicators by entering checks in parentheses on appropriate lines. If the line has two (2) sets of parentheses, check both.

   NOTE: -- PHYSIOLOGICAL MONITORING requires one entry. If POSITION Complete is marked, put checks in both sets of parentheses. The other patient care indicators are marked only as appropriate; e.g.. - if a patient is on room air and receiving no specific respiratory care, there would be no checks for RESPIRATORY STATUS.

3. Total the number of checks in each column and enter the totals on the appropriate lines. Always include the FIXED WEIGHT in Category II.

4. The highest total of checks determines the patient category. If columns have the same total, the higher category is used. The appropriate category number at the top of the columns is circled.

5. Use the "Comments" space to record a special situation which justifies a higher category than indicated by the total. No explanation is needed for a category III when "Special Procedures" is marked.

Attachment C

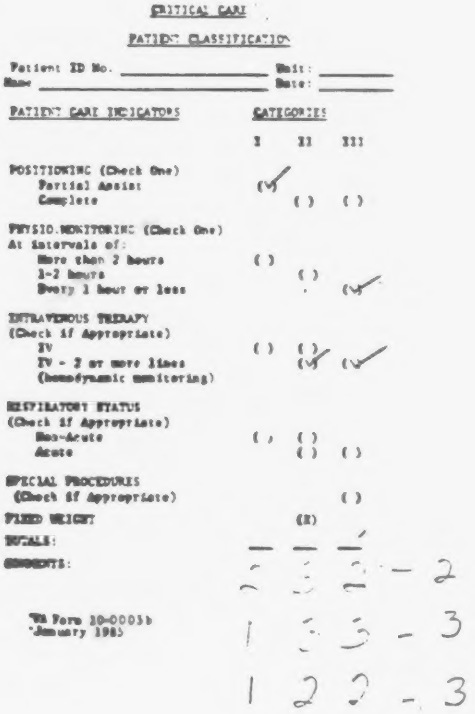
Circular 10-85-82
May 14, 1985

The following are examples of the Critical Care Patient Classification form (VAF 10-0005b). Category I consists of minimal care patients; Category II, moderate care patients; Category III, extensive or complete care patients.

The patient's name, ID number, unit and date are entered at the top of the form.

To classify a critical care patient, check the items that best describe the patient's care needs in each of the five major areas: positioning, physiological monitoring, intravenous therapy, respiratory status, and special procedures.

The number of checks in each column are added vertically and then entered in the row marked "TOTALS" under the appropriate column. The column with the greatest number of checks is the patient's classification. The category should be circled at the top of the form. If there is a tie, the higher category is circled.



CRITICAL CARE

PATIENT CLASSIFICATION

Patient ID No. ____________ Unit: ________
Name ____________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	I	II	III
POSITIONING (Check One)			
Partial Assist	(✓)		
Complete		( )	( )
PHYSIO.MONITORING (Check One) At intervals of:			
More than 2 hours	( )		
1-2 hours		( )	
Every 1 hour or less			(✓)
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	( )	( )	
IV - 2 or more lines (hemodynamic monitoring)		(✓)	(✓)
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WEIGHT		(X)	
TOTALS:	___	___	___
COMMENTS:			

2 3 2 - 2

1 3 3 - 3

1 2 2 - 3

VA Form 10-0005b
January 1985

CIRCULAR 10-85-82
May 14, 1985

CCU I EXAMPLE

Mr. Smith, age 48, was admitted to CCU two days ago with a diagnosis of acute myocardial infarction. His vital signs were stable, heart and lung sounds normal, NSR; enzyme studies and EKGs are returning to normal. Orders include cardiac monitoring with rhythm strips every 4 hours, v.s. checks every 4 hours, IV TKO. Assist with activity OOB X 4 daily with BRP. Plan transfer from CCU in a.m.

CRITICAL CARE

PATIENT CLASSIFICATION

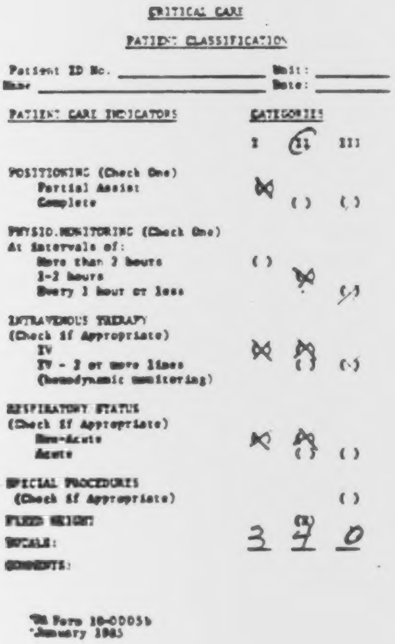
Patient ID No. ____________ Unit: ________
Name ____________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	[✓ I]	II	III
POSITIONING (Check One)			
Partial Assist	☒		
Complete		( )	( )
PHYSIO. MONITORING (Check One) At intervals of:			
More than 2 hours	☒		
1-2 hours		( )	
Every 1 hour or less			( )
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	☒		
IV - 2 or more lines (hemodynamic monitoring)		☒	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WEIGHT		(X)	
TOTALS:	3	2	0
COMMENTS:			

VA Form 10-0005b
January 1985

CCU II EXAMPLE

Mr. Hart, age 72, was admitted to CCU last evening with a diagnosis of cardiomyopathy and arrythmias. BP 100/68, heart rate 90 and irregular, cardiac monitor revealed NSR with frequent multifocal PVC's and episodes of ventricular tachycardia associated with shortness of breath and diaphoresis, respiratory rate 20 and breath sounds diminished. ABG's have stabilized and arrythmies are controlled. Cardiac monitoring continues with rhythm strips every 2 hours, v.s. checks every 2 hours. Mr. Hart needs assistance with turning in bed and getting up to bedside a commode. IV TKO. Oxygen via face mask.



CRITICAL CARE

PATIENT CLASSIFICATION

Patient ID No. ______________ Unit: ________
Name ______________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	I	[✓ II]	III
POSITIONING (Check One)			
Partial Assist	☒		
Complete		( )	( )
PHYSIO. MONITORING (Check One) At intervals of:			
More than 2 hours	( )		
1-2 hours		☒	
Every 1 hour or less			(/)
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	☒	☒	
IV - 2 or more lines (hemodynamic monitoring)		( )	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	☒	☒	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WEIGHT		(X)	
TOTALS:	3	4	0
COMMENTS:			

VA Form 10-0005b
January 1985

CCU III EXAMPLE

Mr. Jones, age 58, was admitted to CCU with severe chest pain radiating to his left arm. Assessment revealed BP 90/60, AHR 58, Resp. 22. EKG showed an irregular heart rate. Skin was cool, clammy and diaphoretic. A Swan-Ganz catheter was inserted and PAWP and vital signs are monitored every 30 minutes. Two hours after admission, Mr. Jones' BP dropped to 60/?, AHR 32. Vasopressors were started IV and a demand pacer was inserted. Mr. Jones suffered acute respiratory failure, was intubated and placed on a ventilator. Mr. Jones' condition continues to deteriorate and preparations have begun for insertion of an IABP.

CRITICAL CARE

PATIENT CLASSIFICATION

Patient ID No. ______________________ Unit: __________
Name ______________________ Date: __________

PATIENT CARE INDICATORS	CATEGORIES		
	I	II	[✓ III]
POSITIONING (Check One)			
Partial Assist	( )		
Complete		( )	( )
PHYSIO.MONITORING (Check One) At intervals of:			
More than 2 hours	( )		
1-2 hours		( )	
Every 1 hour or less			( )
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	( )	( )	
IV - 2 or more lines (hemodynamic monitoring)		( )	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			(X)
FIXED WEIGHT		(X)	
TOTALS:	0	1	1

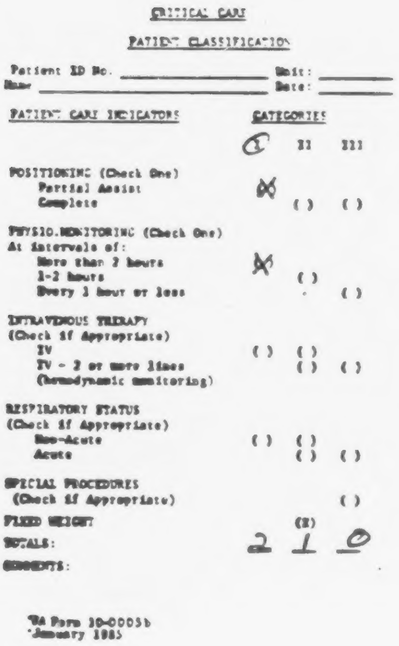
COMMENTS:

VA Form 10-0005b
January 1985

CIRCULAR 10-85-82
May 14, 1985

MICU I EXAMPLE

Mr. Brown, 58 years old, has been a patient in the MICU for the past five days. He was admitted for Upper GI Bleeding. Bleeding was controlled with iced saline lavage and drug therapy. The patient also received multiple blood transfusions. His condition is now stable. Cardiac monitoring and his IV have been discontinued; vital signs are taken every 4 hours. Mr. Brown needs assitance with all activities. He will be transferred to a general medical unit this morning.



CRITICAL CARE

PATIENT CLASSIFICATION

Patient ID No. ____________ Unit: ________
Name ____________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	[✓ I]	II	III
POSITIONING (Check One)			
Partial Assist	☒		
Complete		( )	( )
PHYSIO.MONITORING (Check One) At intervals of:			
More than 2 hours	☒		
1-2 hours		( )	
Every 1 hour or less			( )
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	( )	( )	
IV - 2 or more lines (hemodynamic monitoring)		( )	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WEIGHT		(X)	
TOTALS:	2	1	0
COMMENTS:			

VA Form 10-0005b
January 1985

MICU II EXAMPLE

Mr. Gray, 33 years old, with a diagnosis of Acute Lymphoblastic Leukemia, has been admitted to the MICU for treatment of a pulmonary infection. The infection has been unresponsive to conventional antibiotic therapy. He has been placed in the isolation room. Mr. Gray requires minimal assistance with bathing, feeding and positioning. Vital signs are to be taken every 2 hours, medications are administered every 3 hours. The cardiac monitor shows a sinus tachycardia of 132 BPM, Temperature is 100.4 degrees F., B/P is 112/70. He has one peripheral IV. Mr. Gray is being evaluated for granulocyte therapy.

CRITICAL CARE

PATIENT CLASSIFICATION

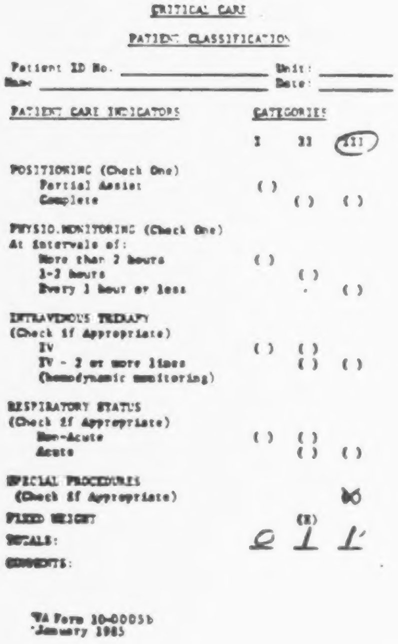
Patient ID No. ______________________ Unit: __________
Name ______________________________ Date: __________

PATIENT CARE INDICATORS	CATEGORIES I	[✓ II]	III
POSITIONING (Check One)			
Partial Assist	☒		
Complete		( )	( )
PHYSIO.MONITORING (Check One) At intervals of:			
More than 2 hours	( )		
1-2 hours		☒	
Every 1 hour or less			( )
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	☒	☒	
IV - 2 or more lines (hemodynamic monitoring)		( )	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WL CAT		(X)	
TOTALS:	2	3	0
COMMENTS:			

VA Form 10-0005b
January 1983

MICU III EXAMPLE

Ms. Murphy, 38 years old with a diagnosis of Guillain-Barre syndrome, is a patient in the MICU. She has been intubated and placed on a ventilator. A peripheral IV and foley catheter are in place. Nursing interventions include chest physical therapy every 2 hours, cardiac monitoring for a junctional tachycardia, and hourly turning. The patient is unable to assist with any activities and is unable to communicate; she is alert. Ms. Murphy is undergoing plasma exchange, an experimental procedure.



CRITICAL CARE

PATIENT CLASSIFICATION

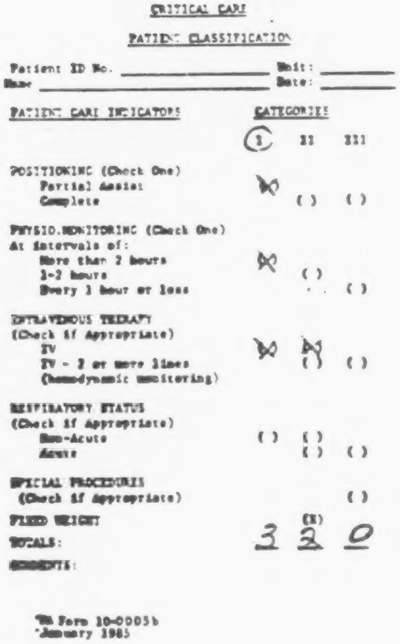
Patient ID No. ____________ Unit: ________
Name ____________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	I	II	[✓ III]
POSITIONING (Check One)			
Partial Assist	( )		
Complete		( )	( )
PHYSIO.MONITORING (Check One) At intervals of:			
More than 2 hours	( )		
1-2 hours		( )	
Every 1 hour or less			( )
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	( )	( )	
IV - 2 or more lines (hemodynamic monitoring)		( )	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			(X)
FIXED WEIGHT		(X)	
TOTALS:	0	1	1
COMMENTS:			

VA Form 10-0005b
January 1985

SICU I EXAMPLE

Mr. James had open heart surgery 4 days ago. His post-operative course has been uncomplicated. His lines have been discontinued, with the exception of the peripheral IV. He requires assistance with bathing and ambulation. Mr. James will be discharged from the SICU to the surgical step down unit today. Vital signs are taken every 4 hours. Medications are administered every 6 hours.



CRITICAL CARE

PATIENT CLASSIFICATION

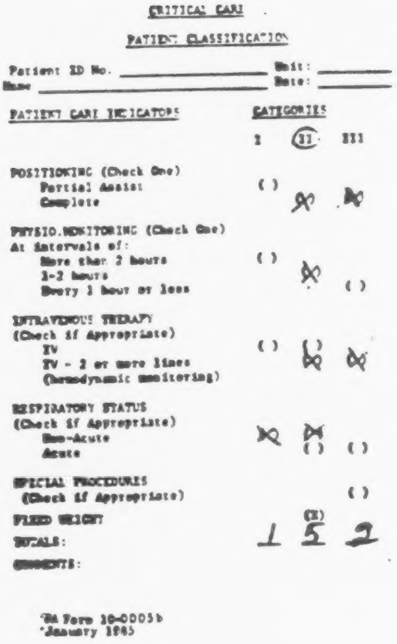
Patient ID No. ________________ Unit: ________
Name ________________________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	[✓ I]	II	III
POSITIONING (Check One)			
Partial Assist	☒		
Complete		( )	( )
PHYSIO. MONITORING (Check One) At intervals of:			
More than 2 hours	☒		
1-2 hours		( )	
Every 1 hour or less			( )
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	☒	☒	
IV - 2 or more lines (hemodynamic monitoring)		( )	( )
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		( )	( )
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WEIGHT		(X)	
TOTALS:	3	2	0
COMMENTS:			

VA Form 10-0005b
January 1985

SICU II EXAMPLE

Mr. Johnson was admitted to the SICU from the RR following a cholecystectomy. had a myocardial infarction 8 months ago. During the operative procedure, . . . Johnson had an episode of ventricular tachycardia with hypotension. The situation responded favorably to Lidocaine. The patient now has occasional PVC's. Vital signs are B/P 134/84, P-84 NSR, R-20. He was extubated in the OR and is now on continuous O2 via face mask. A nasogastric tube and foley catheter are in place. Mr. Johnson's orders include vital signs and rhythm strips every hour. He has 2 peripheral IV's.



CRITICAL CARE

PATIENT CLASSIFICATION

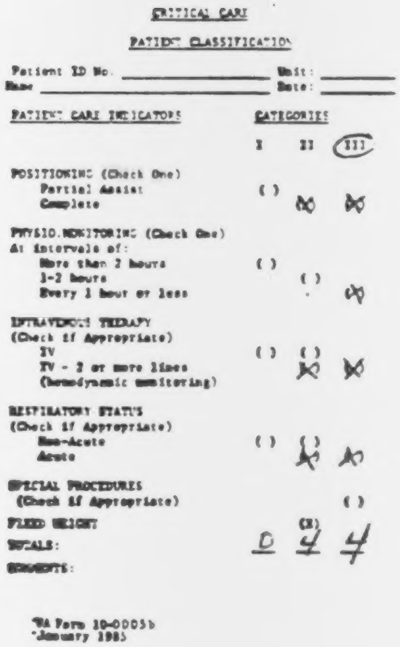
Patient ID No. ____________ Unit: ________
Name ____________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	I	[✓ II]	III
POSITIONING (Check One)			
Partial Assist	☐		
Complete		☒	☒
PHYSIO. MONITORING (Check One) At intervals of:			
More than 2 hours	☐		
1-2 hours		☒	
Every 1 hour or less			☐
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	☐	☐	
IV - 2 or more lines (hemodynamic monitoring)		☒	☒
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	☒	☒	
Acute		☐	☐
SPECIAL PROCEDURES (Check if Appropriate)			☐
FIXED WEIGHT		(X)	
TOTALS:	1	5	2
COMMENTS:			

VA Form 10-0005b
January 1985

SICU III EXAMPLE

Yesterday, Mr. Smith underwent triple vessel CABG. He is now responsive; remains intubated and on a ventilator. He is on vasopressors, has an arterial line, pulmonary artery catheter. Vital sign monitoring is required (q) 30 minutes. Patient requires complete assitance.



CRITICAL CARE

PATIENT CLASSIFICATION

Patient ID No. ____________ Unit: ________
Name ____________ Date: ________

PATIENT CARE INDICATORS	CATEGORIES		
	I	II	[✓ III]
POSITIONING (Check One)			
Partial Assist	( )		
Complete		(X)	(X)
PHYSIO. MONITORING (Check One) At intervals of:			
More than 2 hours	( )		
1-2 hours		( )	
Every 1 hour or less			(X)
INTRAVENOUS THERAPY (Check if Appropriate)			
IV	( )	( )	
IV - 2 or more lines (hemodynamic monitoring)		(X)	(X)
RESPIRATORY STATUS (Check if Appropriate)			
Non-Acute	( )	( )	
Acute		(X)	(X)
SPECIAL PROCEDURES (Check if Appropriate)			( )
FIXED WEIGHT		(2)	
TOTALS:	0	4	4
COMMENTS:			

VA Form 10-0005b
January 1985

SUGGESTED PROCEDURE TO ENSURE INTER-RATER RELIABILITY AMONG NURSES IN CLASSIFYING CRITICAL CARE PATIENTS

Why is Inter-rater Reliability Important?

The determination of workload and nurse staffing requirements are dependent on accurate classification of patients. Inter-rater reliability is a method to establish and maintain consistency in the way nurses classify patients both within an individual nursing unit and among all similar units at each hospital.

In order to check on the internal consistency of the patient classification system, an evaluation of inter-rater reliability must be conducted. Since accurate assessments of patient classification are an integral component in the determination of required nursing hours, the reliability of the patient classification process should be evaluated periodically and corrective measures should be taken when indicated as part on an ongoing program.

Purpose and Scope

The purpose of this procedure is to measure and minimize variability in the way different nurse raters classify the same kinds of patients using the current critical care patient classification system. The procedure is directed at achieving a high level of consistency in patient classification or inter-rater reliability within a health care facility. Efforts to measure and attain high inter-rater reliability among different hospitals within the VA health care system may be taken at a later date.

Who Should Perform this Function?

The success of the patient classification system and the evaluation of inter-rater reliability is dependent upon knowledge of the system and a commitment to it by each nurse who is involved. A registered nurse, designated by the Chief, Nursing Service, should be assigned the overall responsibility to evaluate levels of inter-rater reliability. The nurse assigned this responsibility may be in either a staff role or a management position. This determination should be based on the organizational structure of the Nursing Service and availability of resources. Nurses who should be considered are Nursing Instructors, Clinical Nurse Specialists, Nursing Supervisors, and Head Nurses.

Two additional nurses, designated by the Chief, Nursing Service, should be assigned to assist the nurse who is responsible for this project. Assistants should have a thorough knowledge and demonstrate competence in the nursing care requirements of critical care patients and the patient classification system.

Process

This approach is based on evaluating the consistency of patient classification among nurses, and working with individual nursing units until acceptable levels of consistency are achieved. A reduced frequency of review is then performed to ensure continued high levels of reliable patient classification.

The proposed frequency and scope for evaluating consistency is outline below:

1. Concentrate efforts to achieve acceptable consistency on one unit at a time. Work with that unit only until the goal of 90% consistency is reached; then move to the next unit.

2. The evaluating nurses should classify all patients on the unit every day until 90% consistency is achieved. Consistency, in this instance, will mean that nurses on the unit are following the established procedure for classifying patients, and that there is agreement between the evaluating nurse and the unit nurses in classification assigned to each patient.

3. The evaluating nurse should classify patients without prior consultation with nurse on the unit.

4. Corrective measures should be taken immediately after an evaluation when consistency is found to be less than 90%. This should be done in a helpful and instructive manner with unit staff. Immediate feedback to the Head Nurse is recommended. The participation of the Head Nurse is essential in efforts to clarify points of confusion and to achieve greater consistency.

5. After a unit has achieved 90% consistency, plan to evaluate it again at the end of one month to ensure that 90% consistency is maintained. If classification consistency falls below 90%, continue a more intensive review until problems are corrected.

6. When a unit has maintained 90% consistency at the end-of-month review, plan to review the unit every three months thereafter.

7. Units should not know in advance when a review is to be done.

Guidelines to Aid Reviewers

1. A data collection form should be prepared which contains several sample patient classification cards.

2. Each nurse reviewer will be assigned to a specific unit. To maintain objectivity the reviewer should not be assigned to her/h[illegible]wn unit.

3. The reviewer will indepedently classify patients. This process may include:

--- review of the nursing care plan

--- review of the patient's chart

--- direct patient observation

4. Continue until all patients have been classified.

5. Compare patient classification results obtained through the independent review with the results of the same patients classified by the unit. In reviewing the unit's classification results, it is important to check the accuracy and completeness of the classification cards done by the individual unit. This includes checks on addition and correct procedures in marking the card.

6. Identify inconsistencies between results of the classification done on the unit and the reviewer's results on the data collection form. Discuss these with the Head Nurse or Nurse in charge.

7. Provide further comments on the data collection sheet, as appropriate for each discrepancy, noting whether the variation if justified based on additional information or is considered to be unjustified.

8. Results should be entered on a summary report for each unit. A sample report illustrating the format is shown below.

Inter-Rater Reliability Summary Reports
Critical Care Patient Classification System

Unit	Date of Review	Number of Classifications with agreement	without agreement	Percentage of Consistency

Comments:

9. Example: 15 patients were reviewed and classified. There was inter-rater agreement on 12 patients. Therefore, the percentage of consistency was 12 divided by 15, which is 80%.

Results of the reviews provide a valuable management tool in directing educational and other resources to areas where problems may exist. This information also provides a method to determine the status of the implementation of the patient classification system and the reliability of the data within each Nursing Service.

TABLE I
COMPARISON OF PRESENT AND PROPOSED DISCIPLINARY PROCESSES AND APPEAL RIGHTS
FOR PERMANENT EMPLOYEES FOR ADMONISHMENTS AND REPRIMANDS

PRESENT DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)		PROPOSED DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PRESENT DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR EMPLOYEES APPOINTED UNDER 5 USC
ADMONISHMENTS	REPRIMANDS	ADMONISHMENTS & REPRIMANDS	ADMONISHMENTS & REPRIMANDS
o admonishment issued by employee's immediate supervisor or higher level o right to appeal admonishment on the record to higher level than issuing official o decision letter on appeal issued and no further rights to contest admonishment within the VA	o intent to reprimand issued by employee's immediate supervisor or higher level o right to reply to intent to reprimand o decision letter issued (reprimand) o right to appeal reprimand on the record or request a hearing o decision letter on appeal issued and no further rights to contest reprimand within the VA	o admonishment or reprimand issued by immediate supervisor or higher level o right to grieve action under agency grievance procedure (see Table V) o decision on formal grievance final with no additional rights to contest action within the VA	o admonishment/reprimand issued by immediate supervisor or higher level o right to grieve action under agency grievance procedure (AGP) or negotiated grievance procedure (NGP) (see Table V) o decision on formal grievance final under AGP with no additional rights to contest action within the VA

TABLE II

COMPARISON OF PRESENT AND PROPOSED DISCIPLINARY PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES FOR SUSPENSIONS WITHOUT PAY FOR 14 CALENDAR DAYS OR LESS

PRESENT DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PROPOSED DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PRESENT VA DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES UNDER 5 USC
o Facility Director forwards evidence through Regional Director to Director for Operations o Screening Committee reviews evidence and recommends action to Director for Operations o Director for Operations issues proposed suspension including right to reply o employee right to review cases on the record or request agency grievance procedure hearing before Disciplinary Board o Chief Medical Director issues decision after reviewing transcript, Disciplinary Board's Findings and Recommendations, and remainder of record o employee right to appeal CMD's decision on the record to the Administrator of Veterans Affairs within 15 calendar days. o Administrator's decision issued and final with no further rights to contest action within the VA	o Service Chief or higher level proposes suspension o employee provided right to reply orally and/or in writing and has normally thirty (30) calendar days' notice before decision is effected o decision official issues decision o employee has the right to grieve suspension under agency grievance procedure (see Table V)	o Service Chief or above issues proposed suspension o employee provided right to reply orally and/or in writing before decision is effected o decision official issues decision (may be proposing official or higher level) o employee has the right to grieve suspension under (AGP) or negotiated grievance procedure (see Table V)

TABLE III
COMPARISON OF PRESENT AND PROPOSED DISCIPLINARY PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES FOR SUSPENSIONS WITHOUT PAY MORE THAN 14 CALENDAR DAYS, REDUCTIONS IN GRADE OR PAY, AND DISCHARGES

PRESENT DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PROPOSED DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PRESENT DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR EMPLOYEE UNDER 5 USC
o Facility Director forwards evidence through Regional Director to Director for Operations o Screening Committee reviews evidence and recommends action to Director for Operations o Director for Operations issues proposed action including right to reply o employee right to review of case on the record or request hearing before Disciplinary Board o Chief Medical Director issues decision after reviewing transcript, Disciplinary Board's Findings and Recommendations, and remainder of record o employee right to appeal CMD's decision on the record to the o Administrator of Veterans Affairs within 15 calendar days. o Administrator's decision issued and final with no further rights to contest action within the VA	o Facility official or higher level proposes action o employee right to reply and review of case on the record or request hearing before Disciplinary Board o Chief Medical Director, or designee, issues decision after reviewing transcript, Disciplinary Board's Findings and Recommendations, and remainder of record o employee right to appeal decision on the record to the Administrator of Veterans Affairs within 15 calendar days o Administrator's decision issued and final with no further rights to contest action within the VA	o Service Chief or above issues proposed action o employee provided right to reply orally and/or in writing and has normally thirty (30) calendar days' notice before decision is effected o decision official issues decision o employee has the right to appeal action under negotiated grievance procedure if in bargaining unit (see Table V) or appeal to Merit System Protection Board (MSPB) o MSPB issues final Board decision

TABLE IV
COMPARISON OF PRESENT AND PROPOSED ADMINISTRATIVE PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES FOR REDUCTIONS IN RANK (NOT INVOLVING LOSS OF GRADE OR PAY), DIRECTED REASSIGNMENTS OUTSIDE COMMUTING AREA FOR CAUSE

PRESENT DISCIPLINARY PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES RIGHTS FOR EMPLOYEE APPOINTED UNDER 5 USC 4104(1)	PROPOSED ADMINISTRATIVE PROCESS AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PRESENT ADMINISTRATIVE PROCESS AND APPEAL RIGHTS FOR EMPLOYEE APPOINTED UNDER 38 USC
o Facility Director forwards evidence through Regional Director to Director for Operations o Screening Committee reviews evidence and recommends action to Director for Operations o Director for Operations issues proposed action including right to reply o employee right to review of case on the record or request hearing before Disciplinary Board o Chief Medical Director issues decision after reviewing transcript, Disciplinary Board's Findings and Recommendations, and remainder of record o employee right to appeal CMD's decision on the record to the Administrator of Veterans Affairs within 15 calendar days. o Administrator's decision issued and final with no further rights to contest action within the VA	o Service Chief or higher level informs employee of action o employee has the right to grieve action under agency grievance procedure (see Table V)	o Service Chief or higher level informs employee of action o employee has the right to grieve action under agency grievance procedure or under negotiated grievance procedure if in bargaining unit (see Table V)

TABLE V

COMPARISON OF PRESENT AND PROPOSED GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES FOR ADMONISHMENTS, REPRIMANDS, AND OTHER GRIEVABLE ISSUES

PRESENT GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)			PROPOSED GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PRESENT GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR EMPLOYEES APPOINTED UNDER TITLE 5	
APPEALS OF ADMONISHMENTS	APPEALS OF REPRIMANDS	OTHER GRIEVABLE ISSUES	APPEALS OF ADMONISHMENTS REPRIMANDS, SHORT SUSPENSIONS REDUCTIONS IN RANK, DIRECTED REASSIGNMENTS	APPEALS OF ADMONISHMENTS, REPRIMANDS, AND GRIEVABLE ISSUES	
DM&S SUPPLEMENT, MP-5, PART II, CHAPTER 8, SECTION A	SECTION C OF MP-5, PART II, CHAPTER 8, HEARINGS	SECTION B OF MP-5, PART II, CHAPTER 8, GRIEVANCES (excludes appeals of admonishments & reprimands)	AGENCY GRIEVANCE PROCEDURE, MP-5, PART II, CHAPTER 8, EMPLOYEE GRIEVANCES AND ADMINISTRATIVE APPEALS	AGENCY GRIEVANCE PROCEDURE, MP-5, PART I, CHAPTER 771, EMPLOYEE GRIEVANCES AND ADMINISTRATIVE APPEALS	NEGOTIATED GRIEVANCE PROCEDURE (NGP)
o right to appeal on the record o decision official on appeal issues final decision with no further rights to contest within the VA	o right to appeal on the record or request hearing o decision official on appeal reviews examiner's report and remainder of record and issues final decision	o employee right to file grievance within 30 calendar days o management official at informal stage issues decision, employee has right to file formal grievance	o employee right to file grievance within 15 calendar days o decision official at informal stage issues decision, employee has right to file formal grievance within 10 calendar days o general examination by impartial examiner for all issues; special procedures for certain actions as specified below: o for short suspensions, reductions in rank, and directed reassignments outside commuting area, right to formal hearing, including appearance with representation, opportunity to submit evidence, to call, examine and cross-examine witnesses, and to a written record, upon request o decision official issues decision at formal stage following review of impartial examiner's report of findings & recommendations and remainder of record	o employee right to file grievance within 15 calendar days o management official at informal stage issues decision, employee has the right to file formal grievance within 10 calendar days o general examination at discretion of exam-	o NGP may go through four steps o employee files informal grievance with immediate supervisor within 30 days o immediate supervisor issues decision (step 1) and employee has right to

TABLE V CONTINUATION
COMPARISON OF PRESENT AND PROPOSED GRIEVANCE PROCESSES AND APPEAL RIGHTS
FOR PERMANENT EMPLOYEES
FOR ADMONISHMENTS, REPRIMANDS, AND OTHER GRIEVABLE ISSUES

PRESENT GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)			PROPOSED GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR PERMANENT EMPLOYEES APPOINTED UNDER 38 USC 4104(1)	PRESENT GRIEVANCE PROCESSES AND APPEAL RIGHTS FOR EMPLOYEES APPOINTED UNDER TITLE 5	
APPEALS OF ADMONISHMENTS	APPEALS OF REPRIMANDS	OTHER GRIEVABLE ISSUES	APPEALS OF ADMONISHMENTS REPRIMANDS, SHORT SUSPENSIONS REDUCTION IN RANK, DIRECTED REASSIGNMENTS	APPEALS OF ADMONISHMENTS, REPRIMANDS, AND GRIEVABLE ISSUES	
		within 15 calendar days o decision official issues decision at formal stage following review of examiner's report and remainder of record o employee has right to appeal decision at formal stage on the record to the Chief Medical Director o Chief Medical Director issues a decision on the appeal on the record and employee has no further rights to contest matter within the VA	o decision official's decision at formal grievance is final with no further rights to contest action within the Veterans Administration; except as provided below: o employee may appeal unfavorable decision on short suspension to Chief Medical Director on the record o employee may appeal unfavorable decision on reduction in rank or directed reassignment outside commuting area to the Administrator on the record	iner o decision official issues decision at formal stages following review of impartial examiner's report of findings and recommendations and remainder of record o decision officials decision at formal grievance is final with no further rights to contest action within the VA	grieve to to Service Chief o Service Chief issues decision (step 2) and employee has the right to grieve to Facility Director (step 3) o Facility Director issues decision o Union has the right to contest Director's decision by invoking arbitration

QUESTION: Would you please provide a copy of the General Counsel's opinion concerning the status of employees appointed under Public Law 98-160 concerning access to arbitration procedures?

ANSWER: Here is a copy of our opinion dated August 15, 1984, which fully explains our position on this matter.

QUESTION: What is the situation concerning appeals of adverse actions to MSPB by the "Hybrid Employees?"

ANSWER: There has not been a ruling from the Merit Systems Board concerning the right of these employees to appeal to the MSPB. As of this date two Administrative judges have refused to accept such appeals and one has accepted an appeal. In our view these appeals should be accepted by the MSPB.

QUESTION: Does the VA disagree as a matter of policy that title 5 protections and the existing Labor-Management situation is to apply to all aspects of employment for hybrid employees?

ANSWER: As a matter of law the VA believes that the title 38 personnel system established by Congress is not subject to any inconsistent provisions of title 5. There should not be a different application of this principle with regard to the exercise of Title 38 authorities to appoint, promote and pay hybrid employees. Though the law precludes hybrid employees from using negotiated grievance procedures on the Title 38 issues affecting them, the substantive effects of the preclusion are very narrow. First, the Title 38 issues are few: appointments, pay, promotion. Under the negotiated grievance procedure appointment is made not grievable by 5 U.S.C. § 7121(c)(4). Basic rates of pay are specifically provided by law and are not conditions of employment covered by the labor statute and therefore are not grievable. The promotion of employees is a reserved right of management under 5 U.S.C. § 7106(a)(2)(C) which may not be infringed and is therefore not grievable on substantive grounds. Although employees may grieve under the negotiated grievance procedures the improper use of procedures in determining promotion, under VA regulations Title 38 employees and hybrid employees are entitled to have a promotion denial (not involving a waiver) reviewed on both substantive and procedural grounds, MP-5, Part II, Chapter 5 and VA Circular 00-85-9.

AUG 15 1984

Director, Office of Personnel and Labor Relations (05)

General Counsel (023)

Title II, Public Law 98-160, Veterans' Health Care Amendments of 1983

You have asked us to review a number of issues and questions raised by various sections of title II, Public Law 98-160, The Veterans' Health Care Amendments of 1983 (the Act). We have addressed your questions in the order in which they were asked.

Section 201

QUESTION: "a. The language of new subsection (g)(1) of 38 USC 4106 states that upon the recommendation of the Chief Medical Director, the Administrator may establish qualifications, appoint, promote, and advance individuals listed in Section 4104(3) of title 38 USC. Is the authority to employ these personnel under title 38 USC discretionary at the option of the Administrator? If the authority is not permissive and they must be appointed under title 38 USC, what are our obligations and options with regard to on duty personnel currently serving under title 5 authorities in these occupations? For example, could these personnel remain under Title 5 USC for purposes of appointment and be authorized additional pay on the same basis as nurses under 38 USC 4107(f)?"

ANSWER: The authority in 38 U.S.C. § 4106(g)(1) to establish qualifications for and appoint individuals to positions listed in section 4104(3) and to promote and advance employees in these positions is discretionary. Employees may continue to serve and be appointed to these positions under existing title 5 authorities.

DISCUSSION: First, we believe that the word "may" in new subsection 4106(g)(1), i.e., "the Administrator may use the authorit[ies]" (emphasis added), clearly shows that the authorities to establish qualifications, appoint, promote, and advance individuals are discretionary with the Administrator. Had Congress not intended to allow the Administrator such discretion it would certainly have used mandatory language such as "will" or "shall" rather then "may."

2.

Director, Office of Personnel and Labor Relations (05)

This interpretation of the language of 38 U.S.C. § 4106(g)(1) is supported by the legislative history of the Act. The history makes clear that Congress did not intend to convert the medical care personnel listed in section 4104(3) to the title 38 personnel system:

> The committees decided that these recruitment and retention problems [affecting the positions listed in § 4104(3)] could be addressed without converting these three occupations to the title 38 personnel system, by making certain amendments to title 38 to give the Administrator significant new authorities for use in hiring individuals in the three occupations and in setting their rates of pay.

129 Cong. Rec. S15,354 (daily ed. November 3, 1983) (statement of Sen. Simpson). This statement by Senator Simpson on the floor of the Senate clearly reflects Congress' intent to broaden, not limit, the Administrator's authorities.

Section 201

QUESTION: "b. 38 USC 4104(1) as implemented in MP-5, Part II, Chapter 2, provides only for probational and permanent full-time appointments. Part-time and temporary appointments, however, may be made under the authority of 38 USC 4114. Since Public Law 98-160 does not contain an amendment to 38 USC 4114, may we make part-time and/or temporary appointments for more than one year of Licensed Physical Therapists, Registered or Certified Respiratory Therapists, and Licensed Practical or Vocational Nurses under 38 USC 4104(3)? If not, are we limited in our authority to employ these personnel under Title 5 USC?"

ANSWER: Licensed physical therapists, registered or certified respiratory therapists, and licensed practical or vocational nurses may be appointed on a part-time or temporary basis either under 38 U.S.C. § 4114 or under title 5 authorities. They may not be appointed on a part-time or temporary basis under 38 U.S.C. § 4104(3).

DISCUSSION: The language of section 4104 does not expressly exclude part-time or temporary appointments from its scope, and section 4114 does not expressly state that it is the exclusive authority for part-time or temporary appointments. However, had Congress intended to allow part-time and temporary appointments under section 4104, section 4114 would have been unnecessary. "It is the general rule that where general statute [in this case section 4104] standing alone would include the same matter as the special act [in this case section 4114], and thus conflict with it, the special act will be considered as an exception to the general statute . . . ." 2A Sutherland Statutory Construction § 51.05 (3rd ed. 1973). Only under section 4114 is there any authority for paying part-time temporary appointees. Further, by their plain meaning, the restrictions on the duration of part-time and temporary appointments found in section 4114(a)(3) apply to all such appointments. Thus, in our opinion, licensed physical therapists, registered or certified respiratory therapists, and licensed practical or vocational nurses may be appointed on a part-time or temporary basis only under 38 U.S.C. § 4114 or under title 5 authorities, and not under the amended section 4104.

Section 202

QUESTION: "Employees appointed under the new 38 USC 4104(3) are not included in the reference to a citizenship requirement in 38 USC 4105(b). It appears that these appointments would be subject to Appropriation Act restrictions (FPM Chapter 300, para. 11-3). Are there any other statutory restrictions on the appointment of non-citizens under 38 USC 4104(3)? Do we have the authority to establish citizenship requirements by regulation?"

ANSWER: Employees appointed under the authority of title 38, U.S.C., to positions listed in 38 U.S.C. § 4104(3) are not subject to the citizenship requirements in 38 U.S.C. § 4105(b) and in 5 C.F.R. § 7.4. They are, however, subject to appropriation act restrictions. Employees in the positions listed in section 4104(3) who are appointed under title 5 authority would, however, be subject to the citizenship restrictions in 5 C.F.R. § 7.4. The VA has authority to promulgate citizenship requirements for employees appointed under title 38, United States Code, to positions listed in section 4104(3).

DISCUSSION: We agree that employees appointed under the authority of 38 U.S.C. § 4104(3) are not included within the restrictions of 38 U.S.C. § 4105(b) and that these appointments, like all appointments of Federal employees, are subject to appropriation act restrictions. However, the question whether there are other restrictions on the appointment of noncitizens under

38 U.S.C. § 4104(3) depends on whether such employees are "excepted from the competitive service." We believe that, for purposes of citizenship requirements, they are.

In the exercise of his authority under 5 U.S.C. §§ 3301 and 3302 to prescribe "regulations for the admission of individuals into the civil service in the executive branch" and to "prescribe rules governing the competitive service," the President issued Executive Order 11935 (September 2, 1976). This Executive Order amended Part 7 of title 5, Code of Federal Regulations, to provide, in part, that "no person shall be given any appointment in the competitive service unless such person is a citizen or national of the United States." In contrast, there are "[i]n general, . . . no citizenship requirements for positions in the excepted service" other than appropriation act restrictions on the expenditure of funds. Federal Personnel Manual, Chapter 300, Subchapter II, paragraph 11a.

"The competitive service consists of (1) all civil service positions in the executive branch, except-(A) positions which are specifically excepted from the competitive service by or under statute . . . ." 5 U.S.C. § 2102. "[T]he excepted service consists of those civil service positions which are not in the competitive service or the Senior Executive Service." 5 U.S.C. § 2103.

Under 38 U.S.C. § 4106(g) (which refers to section 4106(a)), the Administrator may "without regard to civil service requirements" "establish the qualifications for and . . . appoint individuals to positions listed in section 4104(3)." This authorizes a statutory exception from the appointment and qualifications requirements of the competitive service.

Thus, at least for these purposes, personnel appointed by the Administrator under 38 U.S.C. § 4106(g) would be in the "excepted service" and not subject to the citizenship requirements of 5 C.F.R. § 7.4. (We do not conclude that such personnel would be in the "excepted service" for other purposes, e.g., for MSPB appeal rights.)

As previously stated, the appointment of such employees under section 4106(g) is discretionary with the Administrator. Employees in the section 4104(3) job categories appointed under title 5 authorities would still be in the competitive service and subject to the citizenship restrictions. This creates the anomalous situation of having different citizenship requirements for section 4104(3) employees appointed under title 38 authorities than for the same type employee appointed under title 5 authorities. This situation could be addressed by Agency regulations. Federal Personnel Manual Chapter 300-25, paragraph 11-1 states that although there are generally no citizenship restrictions for positions in the excepted service, "an agency may . . . restrict consideration to United States citizens." The Administrator's authority to establish the qualifications for appointment to section 4104(3) positions is clearly stated in subsection 4106(g).

Section 203

QUESTION: "a. The Veterans Administration has always taken the position that Title 38 employees are not covered by the Fair Labor Standards Act (FLSA). Certified or Registered Respiratory Therapists, Licensed Physical Therapists, and Licensed Practical and Vocational Nurses are currently covered by the FLSA except that the two therapist occupations would typically be exempt from the FLSA overtime provisions. Since these persons may now be appointed under authority of 38 USC 4104(3), would they continue to be covered by the FLSA, if so appointed?"

ANSWER: Yes, these persons appointed under title 38 authority to the positions listed in section 4104(3) would continue to be covered by the FLSA unless the VA authorizes them to be paid additional pay on the same basis as registered nurses.

DISCUSSION: The argument that title 38 employees are not covered by the FLSA is premised on the fact that, in chapter 73 of title 38, Congress established a personnel system, including pay provisions, entirely separate from title 5 or any other Government personnel system and empowered the Administrator, notwithstanding any other law, Executive order, or regulation, to prescribe by regulation the hours and conditions of employment and leaves of absence of such employees. Congress intended the Administrator to exercise this authority without regard to the pay provisions of title 5, United States Code, and title 5, Code of Federal Regulations. While this argument is valid with regard to employees paid under the title 38 system, it does not generally apply to section 4104(3) employees who are paid under title 5.

As we pointed out earlier, it was not Congress' intention to bring these employees into the title 38 personnel system. Congress only provided the Administrator with certain new authorities to aid in the recruitment and retention of these categories of health care personnel. With regard to pay, the Administrator may, if necessary for recruitment and retention purposes, provide section 4104(3) employees increased rates of basic pay under 38 U.S.C. § 4107(g) or may, under 38 U.S.C. § 4107(f), pay them additional pay on the same basis as title 38 registered nurses under 38 U.S.C. § 4107(e). However, they are not generally under the title 38 pay system. Except for those employees authorized to be paid additional pay on the same basis as registered nurses, section 4104(3) employees remain subject to pay and working condition restrictions, including the FLSA, applicable to other non-title 38 Government employees.

The additional pay provisions of section 4107(e) conflict with the FLSA, and it must be assumed that Congress intended specific provisions of section 4107(e) to take precedence. 2A Sutherland Statutory Construction § 5105 (3rd ed. 1973). It is, therefore, our opinion that section 4104(3) employees for whom the Administrator authorizes additional pay on the same basis as registered nurses under section 4107(e) would be exempt from the FLSA overtime and additional pay provisions.

QUESTION: "b. 38 USC 4106(c) and (g) give the Administrator discretion to develop a plan for advancements within grade. On appointment under 38 USC 4104(3), it would appear that 38 USC 4106(c) and (g) take precedence over 5 USC 5335, because of 38 USC 4119. Are we correct in our view concerning this matter?"

ANSWER: Yes, section 5335 conflicts with VA authority under section 4106(c) to prescribe by regulation the conditions for within grade advancements. Based on section 4119, therefore, section 5335 shall not be considered to supersede, override or modify subsections 4106(c) and (g). The VA may thus prescribe regulations for within grade advancements of employees in positions listed in section 4104(3) without regard to section 5335.

DISCUSSION: Subsection 4106(g)(1)(B) of title 38, United States Code, provides that the Administrator may, upon the recommendation of the Chief Medical Director, "use the authority provided in subsection [4106(c)] for the promotion and advancement of Veterans' Administration employees serving in [positions listed in section 4104(3)]." Subsection 4106(c) provides in part "[a]dvancement within grade may be made in increments of the minimum rate of basic pay of the grade in accordance with regulations prescribed by the Administrator." Section 5335 of title 5, United States Code, provides that employees who are not at the maximum rate of pay for their grade and who are performing at an acceptable level of competence shall periodically be advanced (at intervals set out in the section) to the next higher rate within their grade. Thus, section 5335 conflicts with the authority of the Administrator under 4106(c) to prescribe by regulation the conditions for such advancements. As you suggest, under 38 U.S.C. § 4119, section 5335 shall not "be considered to supersede, override or otherwise modify" the provisions of subsections 4106(c) and (g). The Administrator may prescribe regulations for within grade advancements of employees in positions listed in section 4104(3) without regard to the provisions of 5 U.S.C. § 5335.

That this result was intended by Congress is reflected in the legislative history of Public Law 98-160. The Senate Committee on Veterans' Affairs Report accompanying S. 578 states (regarding language that is identical to that which was eventually included in Public Law 98-160): "The use of the authority in present section 4106(c) for promoting and advancing individuals would also be given to the Administration. This authority is also more flexible than the comparable title 5 authority." S. Comm. on Veterans' Affairs, Veterans' Health Care and Programs Improvement Act of 1983: Report to Accompany S. 578, S. Rep. No. 145, 98th Cong., 1st Sess. 51, (1983).

QUESTION: "c. The new subsection (g)(2) of 38 USC 4106 states that the Administrator shall apply the 'principles of preference' for hiring of veterans established in Subchapter 1 of Chapter 33 of Title 5. Chapter 33 includes 5 USC 3309 which assigns 5 and 10 points in competitive examinations to certain preference eligibles. Are we required to establish a numerical rating system in order to apply the 'principles of preference' to the employment of persons under 38 USC 4104(3)? Similar questions arise about our obligations to establish requirements similar to those in 5 USC 3311, 3312, 3313, 3314, 3316, 3317, and 3318."

ANSWER: It is not necessary to establish a numerical rating system in order to apply the principles of preference to persons employed under 38 U.S.C. § 4104(3). Congress intended section 4106(g)(2) to require the VA to apply only the principles of veterans preference found in subchapter 1 of chapter 33 of title 5, United States Code, and not the exact provisions of that subchapter.

DISCUSSION: This question has been previously answered in our review of the proposed regulations implementing 38 U.S.C.

8.

Director, Office of Personnel and Labor Relations (05)

§ 4106(g)(2). In summary, it is our opinion that it is not necessary to establish a numerical rating system in order to apply the principles of preference. We base our opinion on the language on the legislative history of Public Law 98-160:

> It is the Committee's intent, by requiring application of veterans preference principles, that the Administrator, when applicants for a position are otherwise approximately equally qualified for a particular opening, will give the advantage to a veteran or other preference eligible and particularly so in the case of a veteran with a serviceconnected disability.

S. Comm. on Veterans' Affairs, Veterans' Health Care and Programs Improvement Act of 1983: Report to Accompany S. 578, S. Rep. No. 145, 98th Cong., 1st Sess. 51 (1983). From this language, it is clear that Congress intended only that the principles of veterans preference found in subchapter 1 of chapter 33 of title 5, United States Code, be applied to section 4104(3) employees and did not intend to require the Administrator to apply the exact provisions of subchapter 1.

Section 204

QUESTION: "a. Our reading of this section notes that no new pay scale or reference to the use of an existing pay scale is included under 38 USC 4107, Grades and Pay Scales, for persons appointed under the new 38 USC 4104(3) authority. Are we to assume that for the purposes of grades and pay scales these persons will remain as they now exist under Title 5 USC, although they will be appointed, promoted, advanced, and have their qualifications evaluated under Title 38 USC?"

ANSWER: You are correct in assuming that section 4104(3) employees appointed under section 4106(g) will continue to be paid under the title 5 pay scales. These employees' grades, however, are not automatically subject to the title 5 grading and classification system. The qualifications (including requirements and restrictions regarding grades and classification) for such employees must be established in accordance with regulations prescribed by the Administrator before they can be appointed.

9.

Director, Office of Personnel and Labor Relations (05)

DISCUSSION: There is no authority in Public Law 98-160, or anywhere else in title 38 or any other statute, for the Administrator to establish separate pay scales or tables for section 4104(3) employees (except special rates under section 4107(g)). Therefore, we agree that section 4104(3) employees appointed under section 4106(g) will continue to be paid under the title 5 pay scales. However, given the language of 4106(g)(1) that "[u]pon recommendation of the Chief Medical Director, the Administrator . . . may use the authority in subsection (a) of this section to establish the qualifications for and . . . to appoint individuals to positions listed in section 4104(3) . . ." and the language in section 4106(a) that such appointments are made "without regard to civil service requirements," it is our opinion that the grades of such employees are not automatically subject to the title 5 grading and classification system. The qualifications for such employees must be "satisfactorily established in accordance with regulations prescribed by the Administrator" before they can be appointed. 38 U.S.C. § 4106(a). Congress intended to provide the Administrator with the authority to determine the qualifications for appointment of these employees without regard to civil service requirements. This necessarily and logically includes the requirements and restrictions regarding grades and classification. Thus the Administrator may, by regulation, establish the grades at which section 4103(4) employees with particular qualifications will be appointed. However, there is no legal impediment to the Administrator adopting the title 5 provisions by regulation.

QUESTION: "b. Section 310(b)(1) of the Omnibus Reconciliation Act of 1982 PL 97-253, as amended by PL 97-346), provides that during the last three-fourths of FY 1984 and during FY 1985, the hourly rates of pay for employees shall be computed by dividing the annual rate of pay by 2,087 hours. These adjustments apply only if the employee's hourly rate of pay is derived under 5 USC 5504(b)(1). If personnel listed under 38 USC 4104(3) are appointed under Title 38 USC, would they be subject to the 2,087 hour computation for basic pay but not for additional premium pay (i.e., 2080 hours concept required by 38 USC 4107(e)(6))? Would they not be covered by the 2,087 hour concept for basic and additional premium pay?"

ANSWER: To compute the additional pay of any section 4104(3) employees authorized to receive this pay, 2,080 is the proper figure by which to divide their annual rate of basic pay. To compute all other types of pay of section 4104(3) employees, 2087 is the proper figure.

DISCUSSION: Subsection 4107(f) of title 38, United States Code, provides in part:

> Notwithstanding any other provision of law, when the Administrator determines it to be necessary in order to obtain or retain the services of [4104(3) personnel], the Administrator may . . . pay persons employed in such positions additional pay on the same basis as provided for nurses in subsection (e) of this section. (Emphasis added).

Paragraph (6) of subsection 4107(e) provides that for the "purpose of computing the additional pay provided by paragraph (2), (3), (4), or (5) of this subsection, a nurse's hourly rate of basic pay shall be derived by dividing such nurse's annual rate of basic pay by two thousand and eighty." This clearly means that for purposes of computing employees' hourly rates of pay for determining additional pay entitlements under subsection 4107(e) and (f), 2,080 is the proper figure by which to divide their annual rate of basic pay.

Section 310(b)(1) of Public Law 97-253, the Omnibus Budget Reconciliation Act of 1982, as amended by Public Law 97-346, provides:

> Notwithstanding any other provision of law, effective with respect to pay periods beginning in fiscal years 1984 and 1985, and applicable in the case of an employee as defined in subsection 5504(b) of title 5, United States Code, any hourly rate derived under section 5504(b)(1) of title 5, United States Code, shall be derived by dividing the annual rate of basic pay by 2,087.

Under 5 U.S.C. § 5504(b), an employee is defined as "an employee in or under an Executive agency." Employees in positions listed in 38 U.S.C. § 4104(3) do not fall within any of the listed exceptions to the 5 U.S.C. § 5504(b) definition of employee. Thus, all personnel listed under 38 U.S.C. § 4104(3) who have not been authorized additional pay under 38 U.S.C. § 4107(e) will have their hourly rate of pay determined by dividing their annual rate of pay by 2,087 during FY 84 and 85. Even those section 4104(3) personnel authorized section 4107(e) additional pay will be subject to having their hourly rate computed based on 2,087 for purposes other than determination of hourly rates for section 4107(e) purposes.

Section 206

QUESTION: "In applying the provisions of the new subsection (b) of 38 USC 4111, would rates of pay above the minimum rate of the appropriate grade apply only to initial appointments or could they be authorized subsequent to an initial appointment?"

ANSWER: The new authority of 38 U.S.C. § 4111(b) cannot be used to provide above minimum rates to DM&S employees subsequent to their initial appointment to a particular position. A current employee may, however, be appointed to a new position at an above minimum rate if the conditions in section 4111(b) are satisfied.

DISCUSSION: Section 4111(b) provides:

> Notwithstanding any other provision of law, the Administrator, after considering an individual's existing pay, higher or unique qualifications, or the special needs of the Veterans' Administration, may appoint the individual to a position in the Department of Medicine and Surgery providing direct patient-care services or services incident to direct patient-services at a rate of pay above the minimum rate of the appropriate grade.

The language of this section shows an intent to limit the authority granted the Administrator to provide above minimum rates to initial appointments to a particular position. The plain meaning of the language "appoint the individual to a position" seems to exclude the possibility of providing above minimum rates to personnel already occupying a position. However, there is nothing in the plain meaning of section 4111(b) which precludes the possibility that a current VA employee could be appointed to a new position at a rate above the minimum.

The Senate Veterans' Affairs Committee Report on S.578, the original bill containing this provision, states:

> This provision would give the Administrator the authority, analogous to that in section 5333 of title 5 for positions above GS-11, to appoint an individual to a

12.

Director, Office of Personnel and Labor Relations (05)

> DM&S position at other than the minimum or entry rate for the grade involved. This authority would be available when appropriate in light of the individual's special qualifications or the existing pay that individual is receiving and which the VA must meet or exceed, or in light of special needs of the VA. This administrative authority should allow the Administrator to respond selectively to individual hiring situations in which a higher salary is warranted without having to make higher salary levels applicable across-the-board to a group of employees in the same job position.

This expression of Congressional intent, particularly that this authority is to be used in "individual hiring situations" and is to be analagous to 5 U.S.C. § 5333 (which applies only to new appointees) clearly reflects that section 4111(b) is intended to be a recruitment, and not a retention, device to be exercised only upon initial appointment to a particular position. However, we don't believe that it is a clear expression of Congressional intent to forbid the Administrator from appointing a current VA employee to a new position at above minimum rates.

In summary, it is our opinion that the authority of section 4111(b) cannot be used to provide minimum rates to DM&S employees subsequent to their initial appointment to a particular position. There is no explicit bar to, or clear statement of Congressional intent against, appointing a current employee to a new position at an above minimum rate if the conditions in section 4111(b) for granting such increased rates are satisfied.

QUESTION: "Our reading of Public Law 98-160, Title II, is that for purposes of probationary periods, reductions-in-force, performance appraisal, leave and hours of duty, and conduct and adverse actions persons appointed under the new 38 USC 4104(3) authority will remain under the provisions of the applicable authorities of Title 5 USC. Are we correct in this regard?"

ANSWER: Yes, except where the Administrator has exercised the authority in Public Law 98-160 to authorize the use of those specific title 38 authorities, personnel listed in section 4104(3) remain subject to the provisions of title 5 which you mention.

13.

Director, Office of Personnel and Labor Relations (05)

DISCUSSION: As stated in our response to your first question Congress, in enacting Public Law 98-160, did not convert the personnel in positions listed in 38 U.S.C. § 4104(3) to the title 38 personnel system. Congress only authorised the Administrator to exercise certain title 38 authorities relating to appointment, qualifications, and pay to improve recruitment and retention with regard to section 4104(3) positions. Thus, it is our opinion that, except where the Administrator has exercised the authority granted him in Public Law 98-160 to authorize the use of those specific title 38 authorities, personnel appointed to positions listed in section 4104(3) remain subject to the provisions of title 5.

QUESTION: "What access will employees included under Title 38 USC 4104(3) have to negotiated grievance procedures? None or just for actions taken in accordance with Title 5 USC? Also, will the current master agreement provisions covering these employees continue to apply even after conversion to appointments under Title 38 USC?"

ANSWER: The negotiated grievance procedures will be available for and the current master agreement will continue to apply to section 4104(3) employees except with regard to actions arising out of title 38 authorities.

DISCUSSION: As previously stated, these employees will not be subject to the title 38 personnel system except for those purposes specifically allowed by Public Law 98-160 and authorized by the Administrator. It is the VA's position that actions taken in accordance with title 38 and regulations promulgated by the Administrator thereunder are not subject to the negotiated grievance procedures. The argument supporting this position is that Congress intended title 38 to be an exclusive personnel system.

However, this argument has application only with regard to actions arising under title 38. It does not apply to actions arising under title 5. Therefore, the negotiated grievance procedures will be available for and the current master agreements will continue to apply to section 4104(3) employees except with regard to actions arising out of title 38 authorities made applicable to them by the Administrator in the exercise of the authority granted him in Public Law 98-160.

JOHN P. MURPHY

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Statement of
E. Elaine Lloyd, MS, RN, CS
President, Nurses Organization of the Veterans Administration (NOVA)

Before the

U. S. Senate Committee on Veterans Affairs

May 21, 1987

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Mr. Chairman and Members of the Committee, I am E. Elaine Lloyd, a Registered Nurse employed full-time as a Clinical Nurse Specialist at the Spinal Cord Injury Center, Veterans Administration Medical Center, Palo Alto, California. I am here today as President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the Committee for the opportunity to appear before you. I am accompanied today by Noreen Sommer, MSN, RN, NOVA Legislative Director. While I speak as the representative of NOVA it is my goal to speak also to the need of Veteran patients for the nursing care provided by over 32,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. This nursing care can be provided only when the VA is staffed with adequate numbers of Registered Nurses and other health care personnel. NOVA is very pleased to testify today on this very important legislation addressing incentives to recruit nurses to the Veterans Administration as well as incentives for nurses to remain in the VA.

Registered nurses are the constants in the hospital--we are there 24 hours every day and seven days a week. We are the observers, the monitors, the teachers, the clinicians who collaborate with the physician and other health care professionals in the care and treatment of hospitalized veterans. With the historic low staff to patient ratios in the Veterans Administration Hospitals, nurses are already running at full speed.

Intravenous bottles and wound dressings can only be changed so quickly, basics such as turning a patient who cannot or does not move unaided or feeding a patient requires nursing time. Psychiatric patients who are a risk for suicide or are placed in restraints to prevent harm to themselves or others frequently require 1:1 nursing care or continuous or frequent observation. Patients can only learn to care for their colostomy or give their own insulin or be weaned from a ventilator at a pace that is safe. Many nurses entered nursing for humanitarian and altruistic reasons and we are not afraid of hard work. What we do fear is that harm will come to a patient because we are unable to give them the nursing care they need. As nurses we believe the Veteran patient gets less than he deserves when there are less than adequate numbers of nurses to provide care.

The VA is currently not staffing to its own staffing methodology guidelines. The VA's own staffing methodology study estimates the VA is 8,200 nurses short of what is required to operate the system. NOVA members throughout the country report acute shortages of both RNs and LPNs in their own VA Hospitals.

As the shortage of nurses in VA Hospitals increases, the patient to nurse ratio increases. Nurses are asked to work overtime and doubleshifts. Studies have shown over half of VA nurses work overtime about once a week. Overtime pay creates havoc with the budget. Nurses are further stressed when asked to work multiple shifts in the same week to fill in the gaps on top of their existing shift rotation which in itself is a disincentive in the VA. All of the above compounds the retention problem and VA nurses are lured to the private sector which can offer more stable work schedules, often without rotating shifts, better patient to nurse ratios, higher salaries and better fringe benefits including tuition reimbursement. "On call" pay for operating room nurses and others is higher in the private sector. The solution to these shortages is not forthcoming because, for the same reasons nurses are leaving, the VA is not competitive in recruiting RNs in the midst of a national shortage of nurses.

Shortages are nothing new. The widespread nursing shortages of the late 1970s and early 1980s had a severe impact on staffing in the VA Medical Centers. In August 1980 PL 96-330 called for the VA to conduct pilot programs and a study of actions that would enable the VA to recruit and retain sufficient qualified nursing personnel. 9,000 VA nurses responded to the survey--an overwhelming response. Fortunately for the Congress and the VA, further study of VA nurses is not required at this time. The data derived from the 1981 study supported the results of smaller studies made in the 1960s and 1970s in which demanding work schedules, inadequate staffing and a lack of opportunity for continuing education were seen as causes for dissatisfaction.

Let us review some of the recommendations of the 1981 study and current progress or lack of progress in implementation:

Tuition Reimbursement

Tuition assistance or reimbursement is an important incentive which as been used for many years in the private sector for both recruitment and retention. In 1985 the American Hospital Association Survey found that 70% of the hospitals they surveyed paid tuition reimbursement. The 1986 VA survey found that 77% of the VAs reported that they were at a disadvantage in competition with other facilities for RNs because others offered tuition reimbursement. The 1980 Recruitment and Retention Study recommended that tuition reimbursement should be offered to all nurses enrolled in courses that enhance their work.

NOVA was pleased to learn of the long awaited decision by the VA to address this issue of tuition reimbursement with a 2.5 million dollar pilot program for FY87. Our purpose today is to support Senator Cranston's legislation that will assure that a viable program of tuition reimbursement will continue in FY88 and the years ahead. A viable program will require sufficient funds and a simplicity of implementation such as the broad tuition support program guidelines prepared for the FY87 pilot program. NOVA supports the legislation before us with the following reservations. A tuition reimbursement program that requires 2 years of full time employment prior to eligibility is an outstanding retention tool but will do very little for recruitment. Tieing the qualifications for tuition reimbursement to superior performance would eliminate those nurses new to the VA who even after two years of employment would not be expected to be functioning at the superior performance level. Additional education in fact may assist them to achieve superior performance. A workable tuition reimbursement program will give a loud and clear message from the VA and the Congress to the VA nurse that we have a vested interest in your future and we care about your professional growth. NOVA commends you Mr. Chairman for introducing this legislation and for your historic record of support of VA Registered Nurses.

Staffing Levels

The 1986 VA survey reports that "as a whole the Agency is maintaining adequate staffing levels," when in fact, 54.5% of all facilities reported a moderate to severe difficulty in recruitment and retention of Registered Nurses. Reflect for a moment on one California hospital reported as having only moderate difficulty in September that by November had closed 30 medical/surgical beds and 50 locked psychiatric beds. What has happened to the hospitals with serious and severe difficulty in recruitment and retention of Registered Nurses? Though numbers and percentages have a place in this discussion, what they do not address are the issues of errosion of morale when positions remain vacant for long periods of time and staff are asked to do more and more.

The VA's identified shortage of 8,200 nurses is felt even in hospitals that report no recruitment and retention problems. Nurses report unrealistic workloads caused by unrealistic allocations of nursing staff. Our members report nurses are frequently taking work home rather than denying care to our veteran patients. As one of our NOVA members a Registered Nurse and VietNam veteran from Pennsylvania wrote so clearly about his hospital's workload:

> "Presently we are being impacted with the following 'buzz' words--productivity, time management, and utilization of human resources. Aside from the production line overtone of this I find myself wanting to scream---HEY...WE ARE TAKING CARE OF PEOPLE--YOU KNOW--HUMANBEINGS. WE AREN'T MANUFACTURING COMPUTERS OR AIRPLANES WE ARE CARING FOR INDIVIDUALS. . . . How are we going to attract the bright young caring people our profession so desperately needs as we become a 'Sweat Shop Industry'?"

NOVA's concern is that inadequate staffing causes increases in overtime, doubleshifts and the frequency of shift rotations. Until staffing levels are improved we will be unable to make progress towards the 1981 recommendations that stated:

> "Staffing patterns should be developed to eliminate rotation to different tours of duty" and "Flexible work schedules should assure nursing personnel of every other weekend off duty."

The problem with staffing levels affects not only those nurses currently working at the VA but it is NOVA's belief that it is a negative factor in recruitment.

A study in Arizona of nursing students who had affiliated with the VA revealed that these students did not choose VA employment because they had observed that VA nurses work too hard. In other words the workload was too great. The VA's own survey showed that job factors and working conditions accounted for 33% of those who declined employment.

Salary Rates and Pay Options

NOVA is alarmed with the VA's 1986 survey data on the private sector pay comparison. Only 54% of VA facilities report that salaries are comparable to or greater than those in local non-federal medical facilities. This is particularly disturbing in light of the fact that the congress has given authority to the VA to pay special salary rates to assure pay comparability. Presently 92 facilities use special salary rates to address the disparity between the VA and the community. NOVA asserts that the special rate has not solved staffing problems because:

1. Staffing often needs to become desperate before facilities look at this option.
2. Approval to use the special rates may take 6-12 months.
3. Historically funding of the special rate must be provided by the facility.
4. The special rate may be in effect but not updated yearly and therefore does not remain comparable to the private sector.

These problems with the special pay rates may contribute to the survey finding that "50% of facilities reported regularly scheduled general pay increases at other medical facilities in their areas placed them at a disadvantage in hiring and retaining Registered Nurses." Assuring that nurses on special salary rates also receive the Federal Employee Cost of Living Adjustment would prevent the severe discrepancies between the VA and the private sector. When 40% of those applicants who declined employment gave salary as the reason for declining, the VA should get the message. How can the VA be expected to solve its recruitment and retention problems unless pay comparability is closer to 100%?

Additionally, 41.5% of the VAs report they are at a disadvantage in comparison to other facilities when it comes to paying weekend premium pay. This failure to be competitive in weekend premium pay is astonishing to NOVA as

I am sure it is to you, Mr. Chairman, when the congress in PL 97-251 authorized the VA to institute the Baylor Plan and Saturday premium pay.

To date NOVA is unaware of any VA paying Saturday premium pay. Therefore we are pleased to support Senator Cranston's legislation instituting Saturday premium pay. The success of this historic step is dependent on the assurance of adequate funding being budgeted and allocated.

S713 Registered Nurse Variable Incentive Bonus Act of 1987

The floor statement by Senator Murkowski introducing S713 was hailed by VA nurses who observed in the Senate gallery and those who later read it as 100% right on target. The bill itself causes us to pause.

The bonus program as proposed would have a positive effect on nurse recruitment to the VA. While the bill provides substantial flexibility to the facilities to offer up to $20,000 to a newly appointed nurse, it does not specify how or if the same provisions will be made for nurses who now have appointments and who are currently working in the Veterans Administration. A bonus bill of this magnitude would have a significant negative impact on our nurses if it did not address some additional compensation package to include nurses presently employed. Many have already indicated they would quit and wait to be recruited with a bonus. Our members have also expressed concern that nurses on this program could be arbitrarily uprooted and reassigned under subsection (b) paragraph 2.

In summary NOVA supports the initiatives for Tuition Reimbursement, Saturday Premium Pay and the RN Bonus with the changes we've included. We also exhort the VA and the Congress to take steps to increase staffing levels and to assure that VA salaries for nurses are comparable to the private sector.

NOVA requests this action on behalf of the competent and caring professional nurses working in the VA system who wish to continue with the mission of providing "care that will assist Veterans in maintaining or regaining health, learning to live with disabilities, or dying with dignity and comfort."

Text of Testimony Given to
Senate Committee on Veterans Affairs
May 21, 1987
by Mary D. Naylor, Ph.D., F.A.A.N., R.N.
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INTRODUCTION

An acute shortage of qualified nurses is shaping up across the country, with far-reaching implications for the health of this nation. This situation is compounded by a significant decrease in nursing school enrollments as traditional candidates turn to other career options. The national pool of high school and college students indicating an interest in nursing has declined dramatically over the past few years, well beyond demographic expectations. These major changes in the current and future supply of nurses are occurring at a time when the need for highly sophisticated, caring nurses is more urgent than at any period in the profession's history.

ENROLLMENT TRENDS IN BASIC NURSING PROGRAMS: THE NATIONAL PICTURE

All types of basic nursing programs reported decreases in the number of enrollments during the 1985-86 academic year. An 8.1 percent decrease in total program enrollments during this period came on the heels of a 5.3 percent decrease in basic nursing program enrollment in 1984-85. Total enrollments in basic nursing programs as of October, 1985 was 217,955. All regions of the country experienced a decline in nursing student enrollments (NLN, 1986).

As of October, 1985, diploma programs reported a 19 percent decrease; associate degree programs experienced a 7.8 percent decrease; and baccalaureate programs reported a 4.2 percent decrease in nursing student enrollments from the previous year. Table A reflects these changes.

TABLE A

ENROLLMENTS IN BASIC RN PROGRAMS AND PERCENTAGE CHANGE: 1984-85 TO 1985-86

YEAR	ALL BASIC PROGRAMS		BACCALAUREATE PROGRAMS		ASSOCIATE DEGREE PROGRAMS		DIPLOMA PROGRAMS	
	Number of Enrollments	% Change	Number of Enrollments	% Change	Number of Enrollments	% Change	Number of Enrollments	% Change
1984-85	237,232		95,008		104,968		37,256	
1985-86	217,955	-8.1%	91,020	-4.2%	96,756	-7.8%	30,179	-19.0%

Source: Nursing Student Census, 1986. National League for Nursing, 1987.

Approximately 94 percent of the students enrolled in basic nursing programs are female. The number of men admitted to basic RN programs stood at 6,344 or 6.3 percent of total admissions in 1985 (NLN, 1986). This represents a decrease of approximately 1 percent from the prior year. The percentages of Black (8.0%), Hispanic (2.5%) and Asian (1.5%) admissions remained essentially unchanged from 1984-85.

More current data is available regarding changes in enrollments in undergraduate programs leading to a bachelor of science degree in nursing. Two types of students enter baccalaureate nursing programs: generic students who have had no previous nursing education before entering the baccalaureate program; and RN students who are licensed registered nurses and are graduates of diploma or associate degree programs.

Baccalaureate programs who are members of the American Association of Colleges of Nursing (N=392) reported a 12.6 percent decline in full-time and a

2 percent decline in part-time nursing student enrollment from the Fall of 1985 to the Fall of 1986. Table B reports the enrollment change in baccalaureate nursing programs during this period. The total decrease in baccalaureate program enrollment from 1984 to 1986 was 16.9 percent.

TABLE B

ENROLLMENT AND PERCENTAGE CHANGE FROM 1985-86 TO 1986-87 IN BACCALAUREATE NURSING PROGRAMS

Degree	1985-86 Schools	1985-86 Students	1986-87 Schools	1986-87 Students	Percentage Change
BACCALAUREATE					
Generic					
Full-Time	313	70,285	315	60,781	-13.5%
Part-Time	224	10,061	235	8,602	-14.5%
RN					
Full-Time	280	5,947	300	5,873	- 1.2%
Part-Time	286	24,702	312	25,481	3.2%
TOTAL					
Full-Time	359	76,232	356	66,654	-12.6%
Part-Time	320	34,763	330	34,083	- 2.0%

Source: Report on Enrollment and Graduation in Baccalaureate and Graduate Programs in Nursing, 1983-87, American Association of Colleges of Nursing, February, 1987.

Since this country prides itself on the plurality of opportunity, a worrisome dimension to the decline in enrollments is the deprivatization of nursing education. Over the decade 1975 through 1984, there was a 3.5 percent increase in admissions to public RN programs and a 16.6 percent decrease in entrants to private institutions (Styles, 1986).

The age ranges of students admitted to undergraduate nursing programs in 1984 were as follow: 17-21 years old, 60.7%; 22-30 years old, 27.6%; 31-39 years old, 8.6%; 40-49 years old, 2.1 percent and over 50 years old, 1 percent. Many of the older students are pursuing a second college degree with a major in nursing (American Association of Colleges of Nursing, 1986).

ENROLLMENT TRENDS IN GRADUATE NURSING PROGRAMS: THE NATIONAL PICTURE

Master's programs prepare nurses to assume advanced clinical roles as clinical specialists or nurse practitioners. Master's programs showed a decrease in full-time enrollment and an increase in part-time enrollment for the period Fall, 1985 to Fall, 1986. Doctoral nursing programs prepare nurse researchers, administrators and faculty. Doctoral programs show an increase in both full-time and part-time students during this same period. Table C presents enrollment changes in masters and doctoral programs from 1985-86 to 1986-87.

Table C

ENROLLMENT AND PERCENTAGE CHANGE FROM 1985-86 TO 1986-87 IN MASTER'S AND DOCTORAL DEGREE PROGRAMS

	1985-86		1986-87		Percentage
Degree	Schools	Students	Schools	Students	Change
Master's					
Full-Time	159	6,438	166	5,948	-7.6%
Part-Time	169	13,552	181	14,405	6.3%
Doctoral					
Full-Time	35	765	39	802	4.8%
Part-Time	34	1,078	37	1,233	14.4%

Source: Report on Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing, 1983-87, American Association of Colleges of Nursing, February, 1987

QUALITY OF THE NURSING STUDENT APPLICANT POOL

In addition to a significant decrease in the number of individuals pursuing a career in nursing, the profession is faced with a dramatic decline in the quality of the nursing student applicant pool. This decline is reflected in the following data provided by the Educational Testing Service (ETS) of Princeton, New Jersey:

-In 1983-84, there were 191 high school students in Search 6 (PSAT 1200-1600; A grade level) who expressed an interest in nursing as compared to 0 in 1986-87.

-In 1983-84, there were 620 high school students in Search 7 (PSAT 1100-1190; A-B+ grade level) who expressed an interest in nursing as compared with 318 in 1986-87.

-In 1983-84, there were 637 high school students in Search 8 (PSAT 1000-1090; A-B+ grade level) who expressed an interest in nursing as compared with 128 in 1986-87.

THE NURSING SCHOOL APPLICANT PIPELINE

Although a small decline in first-time enrollees has been experienced in the general higher education community, the number of full-time enrollees for all institutions has remained stable. Therefore, the decline in enrollments experienced by nursing schools is not reflective of a diminishing freshman pool. Rather, it is an indication that individuals seeking a professional education are not choosing nursing.

The pool of high school and college students interested in nursing peaked in 1976 and has dropped significantly since then. In 1983, 42,000 first-time, full-time, four-year college freshmen indicated a desire to prepare for a career in nursing. In 1986, the number of first-time, full-time college freshmen desiring a career in nursing had dropped to 19,800. The number of women interested in nursing hit a record low of 5.1 percent. Only 0.2 percent of freshman men wanted a career in nursing (The American Freshman: 20 Year Trends, 1966-85).

More freshman women at four year colleges are choosing pre-med over nursing for the first time. Allowing for average attrition, the expected number of graduates from bachelor's degree programs in nursing in 1990 will be 11,500. This number is significantly less than the 23,000 individuals who are expected to acquire a medical degree that year (American Association of Colleges of Nursing, 1987).

According to the UCLA survey of freshman attitudes, values and life goals, referred to earlier in this report, the declining popularity of nursing as a career is associated with the migration of high school and college students away from the human service professions to business. Business has emerged as the number one major and career goal of today's freshmen. The proportion of women planning business careers has increased by over 500 percent since 1966. Alexander Astin, survey director, says "The most dramatic changes in all the freshman data since 1966 are those that reflect the effects of the Women's Movement and the changing role of women in American Society." Money, status and power are the values freshmen are seeking. Popularity of values generally associated with nursing such as altruism and social concern are waning (The American Freshman: 20 Year Trends, 1966-85).

If the decline in student interest continues, this nation will experience a nursing shortage of dangerous proportions. The solutions to this current threat, however, must depart from past experience. The need for action to stimulate awareness of nursing as a productive and rewarding career is clear.

DEMAND FOR QUALITY GRADUATES OF NURSING PROGRAMS

As noted earlier, major changes in the health field have made the need for highly sophisticated, caring nursing more urgent than at anytime in our history. Major factors contributing to the increasing demand for nurses include: dramatic growth in the elderly population, especially the population 85+; a growing number of chronically ill persons; and continued technological advances in health care.

Trends indicate that by the year 2000, there will be approximately one-half as many college and graduate degree nurses as needed; this represents a deficiency of 619,100 prepared at the undergraduate and graduate levels (Styles, 1986). To achieve the desired number of graduates from undergraduate and graduate level programs by the year 2000 would require more than doubling the enrollment in existing baccalaureate programs.

The percentage of vacant nursing jobs in U.S. hospitals more than doubled between 1985-1986 (American Nurse, 1987). Hospital vacancies jumped from 6.3% to 13% during this same period (1986 Hospital Nursing Supply Survey).

Nurses are being actively recruited by virtually every type of public and private institution and are creating new markets in major corporations, small businesses, schools, government as well as in ambulatory, chronic, and acute health care facilities.

SOLUTIONS

First, let me stress that turning this enrollment picture around is dependent upon 1) enhancing the work environment and reward system for nursing and 2) promoting public understanding of nursing as a respected, desired field of endeavor.

We must mount a national media campaign to publicize the realities of nursing. The presence of many career options in nursing, including roles in business, schools, and government, as well as exciting and challenging opportunities in more traditional settings such as hospitals, home care, and health maintenance organizations should make this an easier task.

We must divert a large segment of the stream of entrants into nursing away from the technical programs into the professional sector by maximizing on the opportunities for baccalaureate and graduate preparation currently available. Action must be taken to recruit the best and brightest of our high school and college students to nursing and to enhance the capability for already practicing nurses to further their education as a means of improving the quality of care provided to the American public.

SUMMARY

Today and in the foreseeable future, this nation will face multifaceted problems in caring for our elderly, for the chronically ill and for those Americans who have limited access to health care. Recent research has demonstrated that nurses can provide cost-effective care to many segments of the population--young mothers with very low-birth weight infants, young men and women with AIDS, individuals with chronic mental and physical illnesses and the frail elderly and their families. Nurses have made life and death differences in intensive care settings. The nursing profession must continue to attract the best and brightest to fully contribute to our nation's quest for excellence in health care (Fagin, 1987).

The health of Americans requires intelligent, sophisticated and caring nurses to offer health services at the lowest cost and highest quality. Legislation must enable this to occur. Nursing is a national resource and properly used can significantly help to solve the health problems we are facing today and anticipating tomorrow (Fagin, 1987). Thank you.

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STATEMENT OF THE AMERICAN ORGANIZATION OF NURSE EXECUTIVES BEFORE THE VETERAN'S AFFAIRS COMMITTEE OF THE U.S. SENATE

MAY 21, 1987

SUMMARY

Although there are more registered nurses (RNs) in the workforce than ever before, this nation is in the midst of a severe nursing shortage of near crisis proportions. The national RN vacancy rate has almost doubled in the last year. A primary contributing factor to the nursing shortage is that demand for RNs in an array of health care delivery systems far exceeds available supply. With increased payer incentives and demands for patients to be hospitalized only where medically necessary and appropriate and hospitalized only as long as absolutely medically necessary and appropriate hospitalized patients have a higher acuity level on average, which translates into the need for more intense nursing care. Additionally, hospitals have responded to inpatient limits and changing health care delivery patterns by diversifying services. The acute care hospital is but the center of a long continuum that includes ambulatory care centers, surgery clinics, and health maintenance organizations on one end, and long-term care facilities and home health agencies on the other. RNs are sorely needed in all settings for the delivery of quality and cost-effective health care.

The American Organization of Nurse Executives has committed significant resources to address nurse recruitment. But wide-spread commitment by all segments of society is needed, because the current nursing shortage affects all Americans. Failure to address the problem as a national priority will contribute to a national disaster in health care.

TESTIMONY

Mr. Chairman, my name is Sheila McCarthy, and I am president-elect of the American Organization of Nurse Executives (AONE), which represents 4,000 nurse executives from health care institutions across the United States. On behalf of AONE's membership, I welcome the opportunity to testify before the Senate Veteran's Affairs Committee on the nation's nursing shortage and the critical need for effective, comprehensive nurse recruitment strategies.

My comments should be considered within the framework of the changing reimbursement system for hospitals in this country. As you are all aware, since the advent of Medicare's Prospective Pricing System in 1983, payment for health care has dramatically changed from a cost-based, retrospective system to a prospective system based on predetermined rates. In today's health care environment, hospitals have strong incentives to provide no more inpatient care than is absolutely medically necessary and appropriate.

With increasing pressure to increase efficiency, only those patients who require the level of skilled care provided in hospitals remain hospitalized. As a result, today's average hospitalized patient is much more severely ill than in the past, and sicker patients require more nursing care. Increasing severity of illness and the subsequent rise in required nursing care is reflected by the change in the ratio of nurses to patients in hospitals for the delivery of services. That ratio jumped from 50 nurses per 100 hospitalized patients in 1975, to 85 nurses per 100 patients in 1985--a 70 percent increase. Current incentives to treat hospital patients more efficiently, create a high demand for RNs, since virtually the same amount of nursing care must be compressed into a shorter period of time. Thus, the need for RNs to provide effective, quality nursing care in this nation's hospitals cannot be disputed.

Increasing demand for outpatient care also adds to the demand for RNs. In the past year alone, outpatient visits to hospitals increased more than 8 percent. With hospitals diversifying services in response to changes in payment and the demand for alternative delivery systems, RNs are needed to provide effective, quality nursing care beyond the traditional four walls of the acute care hospital, such as ambulatory care centers, HMOs, and surgery clinics. A further demand for RNs has emerged in response to changing national demographics. Statistics show that the elderly have increased significantly both in numbers and in proportion to the total U.S. population. In fact, individuals 75 years and older have been identified as the fastest growing segment of this nation's population. The increasing aging population has a whole set of unique health care needs, both in hospitals and in outpatient settings. RNs are clearly prepared to fully provide the kind of nursing care that America's aging population needs in a cost conscious manner.

Coinciding with the need for RNs in today's health care environment is nursing's documented value. A recent study conducted by Medicus, Inc., a Chicago area consulting firm, found that nursing care is an exceptional value from a purely fiscal perspective, representing only about 18 percent of Medicare reimbursement costs, much lower than what nursing care was historically assumed to cost. A second study conducted by researchers at George Washington University School of Medicine, here in Washington, DC, found that nursing care is the most important factor affecting the survival rate of patients in intensive care units. Specifically, the research showed that quality of care was better in hospitals whose nurses were highly independent and in which effective communication exists between nurses and physicians. If these studies are any indication of nursing's value to the health care of this nation's citizens, the American public has much to gain by a health care ~~delivery~~ system supported by sufficient numbers of registered nurses.

The high need and value of nursing has emerged at a time when there are more nurses in the workforce than ever before. In 1977, there were 1.4 million RNs in the nation, and 70 percent were employed on a full-time basis. By the end of 1984 their numbers had jumped to 1.9 million, with more than 79 percent in the workforce.

Despite increased numbers of RNs, however, the country is in the throes of one of its worst nursing shortages. Quite simply, the demand for RNs both in inpatient and outpatient health care delivery setings has far surpassed the available supply.

In December 1986, the AONE conducted a hospital nursing supply survey to determine the extent of the nursing shortage. One-third of our nation's hospitals were randomly surveyed regarding their hospital nursing supply for the week of Dec. 1, 1986; nearly 50 percent of the hospitals returned completed surveys within three weeks. The results of this survey are dramatic and warrant attention.

The survey found that the overall RN vacancy rate in hospitals was 13.6 percent, more than twice the vacancy rate in 1985. While 54 percent of hospitals with less than 50 beds reported vacancies, 97 percent of hospitals with over 200 beds reported vacancies for RNs. The RN vacancy rate varies in different regions of the country. The problem appears to be the worst in the Middle Atlantic, Pacific, and East North Central regions of the country, but trends seem to be spreading from the two coasts inward. Seventy percent of all federal- government hospitals reported RN vacancies, and 77 percent of non-federal government hospitals reported RN vacancies. In non-government hospitals, the for-profits reported a 79 percent vacancy rate, and the not-for-profits reported an even higher rate of 82 percent. More than 90 percent of all hospitals that reported RN vacancies were recruiting for medical-surgical nurses, and 80 percent reported recruiting RNs for vacancies in the intensive care and coronary care units. Significant RN vacancies were also reported for just about every other clinical specialty, including surgery and the emergency room. The results of this survey strongly reinforce how severe this nursing shortage is, because it involves all types of nurses, in all kinds of hospitals, and in all regions of the country.

Moreover, this problem cannot be viewed as a short-term problem, for which quick fix solutions would be sufficient. The scope of the nursing shortage has long-term implications because enrollment levels into basic education programs for nursing have declined within the past few years. For example, between 1983 and 1986, there was a 19 percent decrease in students enrolled in baccalaureate nursing education programs, and a 29 percent decrease in student enrollment in associate degree nursing programs. Such dramatic decreases in student enrollments into nursing education programs means that the nursing shortage we are currently experiencing could potentially get even worse because those schools that traditionally provide sufficient numbers of graduate nurses for the health care industry will soon be unable to supply needed numbers of graduates for employment.

To overcome this nursing shortage of potentially crisis proportions, nurse recruitment must be addressed by all segments of society as a top priority. The nursing shortage is not a problem reserved for the nursing profession. It is germane to the American public's well-being, and therefore, the responsibility of society to collectively address.

Effective recruitment strategies are essential to increase the nurse supply that is sorely needed for all aspects of the health care industry. Unless we increase the number of RNs in proportion to the current and projected demand for nurses over the remainder of this century, the health and well-being of many of our citizens, especially the elderly who are most vulnerable, will be at risk. The question of whether any of us can count on a nurse being there when we truly need it is totally dependent upon whether we act swiftly and effectively to increase this nation's supply of registered nurses. We cannot afford to allow the demand for nurses to continue to escalate faster than the supply.

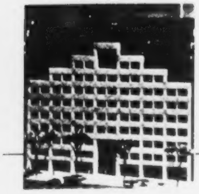
The AONE is currently undertaking a national review of existing recruitment and retention strategies for nurses in hospitals. We are trying to identify what types of recruitment and retention strategies exist, as well as effectiveness levels. Our goal is to distribute this information to the health care field as rapidly as possible, so that hospitals and nurse executives can implement effective recruitment and retention strategies in hospitals throughout the United States. Although this review is not yet completed, a preliminary analysis reveals that some inconsistency exists regarding management accountability for nurse recruitment in hospitals, which could contribute to insufficent attention. Furthermore, quantitative analyses of strategies at the institutional level have generally not been done to determine levels of effectiveness.

AONE as an organization strongly supports the following strategies for nurse recruitment and retention:

- o Increase funds for nursing education to encourage students to enter the profession;
- o Enhance the position of nurses in the workplace, so that a nurse's automony and responsibility can be maximized;
- o Ensure fair and adequate compensation packages for nurses;
- o Enhance the image of nursing as a profession so that nursing is depicted as both an altruistic and financially satisfying career; and
- o Fund special projects to demonstrate effective recruitment and retention strategies for RNs in health care institutions, including outpatient and inpatient facilities.

On behalf of the membership of the AONE; who, as leaders of the clinical discipline of nursing are responsible for the delivery of effective, quality nursing care in health care institutions, I urge consideration of a commitment to nurse recruitment that crosses all boundaries, taps all resources, and tackles all issues. Legislators such as yourselves must act to position the nursing shortage as a high priority issue for the United States. Failure to address this problem as a national priority now will contribute to a national health care disaster for all our citizens, including you and your loved ones.

Thank you.



AMERICAN FEDERATION OF
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IN REPLY PLEASE REFER TO

STATEMENT BY

JOHN MULHOLLAND
DIRECTOR OF FIELD SERVICES
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
(AFL-CIO)

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ON

VETERANS' HEALTH AND HEALTH-RELATED PROGRAMS

ON

MAY 21, 1987

TO DO FOR ALL THAT WHICH NONE CAN DO FOR ONESELF

My name is John Mulholland. I am the Director of Field Services of the American Federation of Government Employees (AFL-CIO). AFGE represents 700,000 employees nationwide including some 17,000 professional employees in the Veterans Administration (VA).

We welcome the opportunity to address four of the bills at issue in this hearing and give our views on the overall status of nurses.

Improving recruitment and retention of the nursing staff within the VA requires addressing the primary concern of all personnel--providing quality patient care. This is especially true of those charged with the hands on practice of caring for the veteran population--the nursing staff. This implies making changes in the overall VA health care system if the nursing staff is to be stabilized.

For example, currently special care units are closed due to lack of staff while the waiting list of veterans grows longer. Regular medical units are shut down while available staff work every alternative work schedule imaginable; ten and twelve hour shifts are common. In many cases, this is the only way to assure an occassional weekend off. The warehousing of our veteran population under the guise of quality medical care must change.

Understaffing, high turnover, and promotion pass-over are but a few of the stumbling blocks to the retaining of quality staff. Lack of premium pay, lack of in-service training programs, disregard for the patient classification system, and working with bare bone minimum staffing levels at all times are reasons for both low recruitment and retention problems.

In an atmosphere purportedly designed for health care, there are no wellness programs for staff. Stress levels and burnout syndrome are high.

AFGE is currently conducting a stress survey among the nurses we represent. Results are due by the end of May. A sample of the survey is provided to this committee, and we will be happy to share the results once they are tabulated.

The long-term solution to the nursing crisis requires that Congress provide increased funding of the VA, especially in the staffing area, and that the agency work cooperatively with the union to design a comprehensive program for those charged with providing hands on quality patient care. We stand ready to do our part.

Turning to the specific proposed legislation, the first bill, S.1136, relates to the role of Disciplinary Boards in disciplinary actions for Title 38 employees. Title 38 employees include most professional employees in the VA such as doctors and nurses.

The bill essentially does two things. It limits the scope of Disciplinary Boards to more serious offenses involving separation, lengthy suspensions, etc. It would leave the minor offenses to internal grievance procedures established by regulation.

We applaud the review of disciplinary procedures of Title 38. The current practices are unfair and are perceived as unfair by the employees. The current system does not bring justice to the workplace.

However, we cannot support S.1136 as drafted. The current problems were aggravated by an unforeseen and unintended consequence of Congress's effort to address the pay problem of these employees. In 1983, Congress removed some VA employees (LPNS) from the pay provisions of Title 5 so that recruitment and retention problems could be more adequately addressed. However, the language was so broad that it has been misinterpreted by the VA to exclude the employees from the labor-management provisions of Title 5. The end result of Congressional efforts to address the pay problems of these employees has been to deny these employees the protections granted to all other professional employees in the federal government.

Congressional support of the Civil Service Reform Act was predicated on the theory that all federal employees would have access to negotiated grievance procedures. The exceptions to this were the CIA, FBI, DEA, and other like agencies. Clearly, VA employees should not be included in the excepted groups.

The latest figures from OPM indicate that there are 135,263 professional employees in bargaining units in the federal government. Outside of the VA, all of these employees are covered by a negotiated grievance procedure for review of disciplinary actions. Included are doctors and nurses at military hospitals and the Public Health Service, lawyers, engineers, chemists, scientists, etc.

There is not a shred of evidence that an impartial review of disciplinary actions has had any detrimental effects on the operation of Department of Defense or any other agency which employs professional employees.

Moreover, in the VA, 101,000 nonprofessional employees, including nursing assistants and dieticians, as well as some professional employees such as psychologists, scientists, vocational rehabilitation counselors, etc., are covered by a negotiated grievance procedure. Thus, we have the untenable situation where one group of bargaining unit employees are working side-by-side with other bargaining unit employees with disparate treatment with regard to review of disciplinary actions. Not only is this unfair and demoralizing to employees, but it is poor personnel management.

We urge this committee to include language which would return these employees to parity with all other professional employees by entitling them to a negotiated grievance procedure (including binding arbitration) to review any and all disciplinary actions. (We are attaching sample language which would accomplish this goal.) At a minimum, those disciplinary actions not subject to the Disciplinary Boards should be covered by the negotiated grievance procedure instead of an agency grievance process.

S.1065 would authorize the VA to force Title 5 health care support employees such as x-ray, laboratory, and operating room technologists and technicians into an "on-call" basis. This would restrict these employees to remaining in the commuting area and they would need to be available for contact. Currently if the VA is to assure that these employees are available for work they must be placed on "standby" duty status (whereby they are physically confined to their duty stations).

The bill would also authorize pay for such "on-call" duty. Such pay is not currently available to civil service employees.

The VA justifies this bill primarily on cost grounds--on-call pay is much less costly than standby pay.

While sensitive to the VA needs, we oppose this bill as currently written. We have negotiated language to which VA has agreed precisely on this topic. The contract language reads:

> "Employee participation in an on-call status that requires the employees to restrict their activities (such as to remain at home, leave a phone number, carry a pager, etc.) to asure that they may be reached during non-duty hours for emergency services is voluntary."

Congress should not be in the practice of overruling contract language freely negotiated between the parties.

In addition, this bill could create many instances of abuse of employees. Many small VA hospitals have only two or three individuals for a particular job, for example, x-ray technicians. These individuals would likely be placed "on-call" for most of their non-duty hours. This would severely restrict their off-duty activities (i.e., weekend trips, hunting and fishing activities, etc.)

We believe that the committee could achieve the VA's goal without impinging on the employee's off-duty time. In its transmittal letter, the Administrator, Thomas Turnage, notes that the "lack of pay for ['on call'] duty means these employees have very little incentive to voluntarily agree to hold themselves 'on call'". If Congress allowed these employees "on call" pay, we think the existing voluntary system would become viable and yet would not penalize particular individuals.

S.1062 seeks to clarify the Chief Medical Director's authority over the Professional Standards Board's (PSB) recommendations on probationary employees and increase the flexibility of PSB recommendations as these relate to probationary employees.

We have no problem with granting more flexibility to the PSB, but Congress should require progressive discipline in such actions. The Chief Medical Director's authority to modify or set aside the recommendations of the PSB should be limited to the Chief Medical Director in the VA central office.

Finally, we want to take this opportunity to express our appreciation to Chairman Cranston for the introduction of S.1195. We believe that enactment of this legislation would signal to all the VA nurses and other VA employees that their work is noticed and deemed important.

The bill proposes to move pharmacists and occupational therapists into the Title 38/Title 5 "hybrid" catagory to provide additional pay flexibility to address the recruitment and retention problems in these positions. We have no objections to this shift as long as these employees do not lose important benefits such as access to a negotiated grievance procedure. It is essential that the bill include language to this effect given the aforementioned problems created when LPNs were moved into this hybrid catagory.

Opening the Health Professional Scholarship program to physical therapists (PT) is a sound proposal to begin to address the 22.9 percent vacancy rate for PTs in the VA.

Finally, we heartily applaud the proposals on Saturday premium pay and tuition reimbursement. Nurses who are our members have continually pointed to private sector nursing practices which generally grant more weekend time off and provide premium pay for Saturday work. The proposal on premium pay is a welcome step in addressing this disparate treatment. In a similar fashion, many private sector hospitals offer tuition reimbursement programs to nurses and selected other health care professionals seeking a degree. The proposed program adopts this approach and would enable VA nurses to improve themselves and thereby improve the VA health care system.

Thank you.

ATTACHMENT I

VA NURSING SERVICE
STRESS AND WORKLOAD SURVEY

Dear VA Employee:

The **AFGE National VA Council** is conducting a stress survey and analyzing the results to assess the problems resulting from workload. It is crucial for every nursing service employee to participate completely and honestly. **YOUR ANSWERS WILL BE STRICTLY CONFIDENTIAL** and seen only by the stress consultant and the computer analyst. **DO NOT PUT YOUR NAME ON THE FORM.** Complete the Questionnaire by circling or filling in the answers, please fold it and place it in the provided envelope. The envelope will either be picked-up personally by an AFGE representative or you will be directed to route the survey to the union office through the station mail. The surveys will be given directly to the stress consultant. Upon completion, the results of the stress analysis will be shared with you, and used by the **AFGE/VA Labor-Management Committee** to alleviate stress problems. Thank you for your assistance and cooperation.

Arté Pierce
Arte Pierce
National VA Council President

1. What is your current job classification? ______________________
   Job Title? ______________________
   Job Grade and Step? ______________________

2. What facility do you work for? ______________________

3. What department are you in? (Please check one)
   - a. psychiatric ______
   - b. med/surg ______
   - c. special care units ______
   - d. nursing home/rehab ______
   - e. halfway houses ______
   - f. operating room ______
   - g. clinics/admissions ______
   - h. other ______

4. What shift do you work? (Check One) Day Shift ____ PM Shift ____
   Night Shift ____ Rotating Shift ___

AFGE

Please circle one number for each category.

5. How frequently do you do the following:

	Rarely	1-2x/Mo.	1x/Wk.	2-4x/Wk.	Daily
a. Skip daily restbreaks?	1	2	3	4	5
b. Work while eating lunch?	1	2	3	4	5
C. Skip lunch in order to work?	1	2	3	4	5
d. Come in early to work?	1	2	3	4	5
e. Continue working after hours?	1	2	3	4	5
f. Work compulsory overtime?	1	2	3	4	5
g. Work on Weekends or days off?	1	2	3	4	5

Please indicate,how strongly you agree or disagree with each of the following:

	Strongly Disagree	Disagree	Agree	Strongly Agree
6. My job requires working very fast.	1	2	3	4
7. My job requires working very hard.	1	2	3	4
8. My job allows me to make a lot of decisions on my own.	1	2	3	4
9. I am not asked to do an excessive amount of work.	1	2	3	4
10. On my job, I have very little freedom to decide how I do my work.	1	2	3	4
11. I am free of conflicting demands that others make of me.	1	2	3	4
12. I have a lot to say about what happens on my job.	1	2	3	4
13. I have enough time to get the job done.	1	2	3	4

Here are some items which deal with different aspects of your work situation. Please indicate how often these occur in your job:

	Very Often	Fairly Often	Sometimes	Occasionally	Rarely
14. a. How often are you clear on your job responsibilities?	1	2	3	4	5

	Very Often	Fairly Often	Sometimes	Occasionally	Rarely
b. Does your job require you to keep learning new rules & regulations?	1	2	3	4	5
c. How often can you predict what others will expect of you on the job?	1	2	3	4	5
d. How often are your work objectives well defined?	1	2	3	4	5
e. Are you given enough time to learn the changes in procedures and regulations?	1	2	3	4	5
f. How often are you clear about what others expect of you on the job?	1	2	3	4	5

	Very Satisfied	Somewhat Satisfied	Not Too Satisfied	Not at all Satisfied
15. All in all, how satisfied would you say you are with your job?	1	2	3	4

16. Taking everything into consideration, how likely is it that you will make a genuine effort to find a new job with another employer within the next year? VERY LIKELY __ SOMEWHAT LIKELY __ NOT AT ALL LIKELY __

Here are some items that deal with patient care. How often do these occur?

	Never	Sometimes	Often	Almost Always
17. How often is there a conflict between the needs of the patients & the requirements of the VA?	1	2	3	4

	Never	Sometimes	Often	Always
18. How often is the patient able to obtain adequate services from the VA?	1	2	3	4
19. How often do you have enough time to give to patients?	1	2	3	4

The following statements relate to your immediate supervisor.

	Strongly Disagree	Disagree	Agree	Strongly Agree
20. My supervisor is concerned about the welfare of those under him/her.	1	2	3	4
21. My supervisor pays attention to what I'm saying.	1	2	3	4
22. I am exposed to hostility or conflict from my supervisor.	1	2	3	4
23. My supervisor is successful in getting people to work together.	1	2	3	4
24. My supervisor is helpful in getting the job done.	1	2	3	4

PLEASE REMEMBER TO ANSWER ALL QUESTIONS.

Below are some statements of job-related feelings. Please read each statement carefully and decide how strongly you agree or disagree with each statement. Please circle the number of the scale that comes closest to your feelings.

	Strongly Disagree			—	—	—	Strongly Agree
25. I feel emotionally drained from my work.	0	1	2	3	4	5	6
26. I feel used up at the end of the workday.	0	1	2	3	4	5	6
27. I feel fatigued when I rise in the morning to face another work day.	0	1	2	3	4	5	6

	Strongly Disagree		—	—	—	Strongly Agree	
28. I can easily understand how my patients feel about things.	0	1	2	3	4	5	6
29. I feel I treat some patients as if they were impersonal objects.	0	1	2	3	4	5	6
30. Working with people all day is really a strain for me.	0	1	2	3	4	5	6
31. I deal very effectively with the problems of my patients.	0	1	2	3	4	5	6
32. I feel burned out by my work.	0	1	2	3	4	5	6
33. I feel I'm positively influencing other people's lives through my work.	0	1	2	3	4	5	6
34. I've become more callous toward people since I took this job.	0	1	2	3	4	5	6
35. I worry that this job is hardening me emotionally.	0	1	2	3	4	5	6
36. I feel very energetic.	0	1	2	3	4	5	6
37. I feel frustrated by my job.	0	1	2	3	4	5	6
38. I feel I'm working too hard on my job.	0	1	2.	3	4	5	6
39. I don't really care about quality of my work.	0	1	2	3	4	5	6
40. Working with people directly puts too much stress on me.	0	1	2	3	4	5	6

	Strongly Disagree		---	---	---	Strongly Agree	
41. I can easily create a relaxed atmosphere with my patients.	0	1	2	3	4	5	6
42. I feel exhilarated after working closely with my patients.	0	1	2	3	4	5	6
43. I have accomplished many worthwhile things in this job.	0	1	2	3	4	5	6
44. I feel like I'm at the end of my rope.	0	1	2	3	4	5	6
45. In my work, I deal with emotional problems very calmly.	0	1	2	3	4	5	6
46. I feel patients blame me for some of their problems.	0	1	2	3	4	5	6

HEALTH AND WELL BEING
These questions are about your general state of health and well being.

Here is a list of physical conditions. Please circle how often each has happened to you in the last year. (CIRCLE ONE NUMBER PER STATEMENT).

	Often	Sometimes	Rarely	Never
47.a. Trouble breathing or shortness of breath?	1	2	3	4
b. Pains in the back or spine?	1	2	3	4
c. Becoming very tired in a short time?	1	2	3	4
d. Having trouble getting to sleep?	1	2	3	4
e. Finding it difficult to get up in the morning?	1	2	3	4
f. Find your heart pounding or racing?	1	2	3	4

	Often	Sometimes	Rarely	Never
g. Hands sweating so that they feel damp and clammy?	1	2	3	4
h. Poor appetite?	1	2	3	4
i. Spells of dizziness?	1	2	3	4
j. Having trouble staying asleep?	1	2	3	4
k. Having an upset stomach?	1	2	3	4
l. Having headaches?	1	2	3	4
m. Feeling nervous or fidgety and tense?	1	2	3	4

A REMINDER: YOUR ANSWERS ARE TOTALLY CONFIDENTIAL AND YOU WILL REMAIN ANONYMOUS.

48. How many sick days did you take in the past twelve (12) months?
None (1) ___ 1-3 (2) ___ 4-6 (3) ___ 7-9 (4) ___ 10 or more (5) ___

49. How many sick days did you take during the last twelve (12) months because you felt too exhausted to come to work?
None (1) ___ 1-3 (2) ___ 4-6 (3) ___ 7-9 (4) ___ 10 or more (5) ___

50. In the past twelve (12) months, how many days did you keep working when you were sick?
None (1) ___ 1-3 (2) ___ 4-6 (3) ___ 7-9 (4) ___ 10 or more (5) ___

51. During the past twelve (12) months, have you been disciplined on the use of sick time? Yes (1) _____ No (2) ____

52. If yes, how many times? _____

53. Have you been injured on the job in the last twelve (12) months?
Yes (1) ____ No (2) ____

54. If you were injured, how much working time did you miss as a result of the injury?
Part of a Day (1) ___ 1 Day to 1 Week (2) ___ 1 Week to 1 Month (3) ___
3 to 6 Months (4) ___ 6 to 9 Months (5) _____ Over 9 Months (6) _______

55. Overall, have you seen more co-workers being injured on the job during the past twelve (12) months? Yes (1) ___ No (2) ___

56. Please mark which of the words best describes your life. If your life is somewhere in between, please circle the correct number.

a. Is your life:	**Interesting**	1	2	3	4	5	6	7	**Boring**
b. Is your life:	**Enjoyable**	1	2	3	4	5	6	7	**Miserable**
c. Is your life:	**Worthwhile**	1	2	3	4	5	6	7	**Useless**
d. Is your life:	**Friendly**	1	2	3	4	5	6	7	**Lonely**
e. Is your life:	**Full**	1	2	3	4	5	6	7	**Empty**
f. Is your life:	**Hopeful**	1	2	3	4	5	6	7	**Discouraging**
g. Is your life:	**Rewarding**	1	2	3	4	5	6	7	**Disappointing**
h. Your life:	**Brings Out The Best in You**	1	2	3	4	5	6	7	**Doesn't Give you Much of a chance**

57. Do you feel that you job is having a negative effect on your family?
Yes (1) ___ No (2) ___ .

58. Have you noticed more family tension or arguments when you are stressed at work?
Yes (1) ___ NO (2) ___

59. Do you have high blood pressure?
Yes (1) ___ Borderline (2) ___ No (3) ___ Don't Know (4) ___

60. Do you take tranquilizers or sleeping pills?
Often (1) ___ Sometimes (2) ___ Rarely (3) ___ Never (4) ___

61. If you smoke cigarettes, how many do you smoke per day?
Less Than 10 (1)___ 10-20 (2) ___ More Than 20 (3) ___

62. How many cups of coffee, tea or caffeinated soft drinks do you drink during the day?
None (1) ___ 1-3 (2) ___ 4-6 (3) ___ 6 or More (4) ___

63. In the last year, have you received written patient complaints about your performance?
Never (1) ___ Once (2) ___ More Than Once (3)

64. Has your workload increased in the last twelve (12) months?
Yes (1) ___ No (2) ___

65. If yes, how much harder are you working than a year ago?
10% (1) ___ 25% (2) ___ 50% or More (3) ___

BACKGROUND - REMEMBER, YOUR ANSWERS ARE COMPLETELY ANONYMOUS.

66. For how many years have you worked in your current position? ________

67. How many years have you worked for the VA? ________

68. Since you began working for the VA:
a. How many times have you been promoted? ________
b. How many times have you been given a new job assignment? ________

69. What is your age? ______

70. Are you: Male (1) ___ Female (2) ___

71. What is your racial or ethnic background?
White (1) ___ Black (2) ___ Hispanic (3) ___
Asian (4) ___ Native American (5) ___ Other (6) ___

72. How many years of education have you completed? ____

73. Are you: Single (1) ___ Married (2) ___
Separated/Divorced (3) ___ Widowed (4) ___

74. How many children do you have? ____

ATTACHMENT II

A BILL

To amend Title 38, United States Code to provide certain employees of the Veterans Administration the right to utilize negotiated grievance procedures, and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America, in Congress assembled.

SECTION 1. This Act may be cited as the "DM&S Representation Act of 1985."

SECTION 2. Findings and Purposes.

Congress finds that certain employees of the Veterans Administration, Department of Medicine and Surgery, are being limited to the disciplinary procedures provided under 38 U.S.C. 4110 and regulations issued pursuant thereto. Therefore, it reiterates its intention expressed in enacting Section 7121(e)(1) of the Civil Service Reform Act of 1978, to provide an option for civil service employees to contest matters either under negotiated grievance procedures or under other available statutory appellate procedures and it enacts this measure for the purpose of insuring employees of the Veterans Administration of their right to contest disputes under negotiated grievance and arbitration procedures and to insure that jurisdiction of Disciplinary Boards is limited to matters involving professional proficiency.

SECTION 3. Disciplinary Boards.

Section 4110 of Chapter 73, Title 38, United States Code, is amended by adding the following new subparagraphs:

"(f) Disciplinary Boards shall not be utilized to determine charges other than those involving the determination of professional proficiency in the performance of duties."

"(g) In the event a labor organization has been accorded exclusive recognition, pursuant to Section 7111 of Title 5, of a unit which includes employees covered by this section, then such organization shall have the right to negotiate grievance and arbitration procedures for all disputed matters including those covered by this section."

SECTION 4. Labor-Management Relations.

Section 4119 of Chapter 73, Title 38, United States Code is amended to read as follows:

"Section 4119. Relationship between this subchapter and other provisions of law.

"(a) All provisions of Chapter 71, Title 5, United States Code, shall be applicable to each employee covered by the provisions of Chapter 73 of Title 38.

"(b) Notwithstanding any other provision of law, no other provision of Title 5 or any other law pertaining to the civil service system which is inconsistent with any provisions of this subchapter shall be

> considered to supercede, override, or otherwise modify such provision of this subchapter except to the extent that such provision of Title 5 or of such other law specifically provides, by specific reference to a provision of this subchapter, for such provision to be superceded, overridden, or otherwise modified."

SECTION 5. Effective Date.

The provisions of this Act shall become effective immediately upon passage.

NATIONAL
FEDERATION
OF FEDERAL
EMPLOYEES

NFFE

1016 16th St., N.W.
WASHINGTON, DC
20036
(202) 862-4400

STATEMENT

BY

THE NATIONAL FEDERATION OF FEDERAL EMPLOYEES

BEFORE

THE SENATE COMMITTEE ON VETERANS' AFFAIRS

ON

THE RECRUITMENT AND RETENTION OF HEALTH CARE PERSONNEL

MAY 21, 1987

Mr. Chairman and Committee Members;

My name is Tricia Thomas, and I am the Legislative Director of the National Federation of Federal Employees. With me today is Elayne Tempel, a Labor Relations Specialist who works with the Veterans' Administration (VA) Council of NFFE Locals. The NFFE represents employees of every occupation, both professional and nonprofessional, within the VA hospital system. Our members include registered nurses (RNs), licensed practical nurses (LPNs), doctors, dentists, pharmacists, engineers, even police officers and firefighters to name just a few of the positions. For the most part, these employees have served the Veterans' Administration for many years, devoting their careers to the care of this nation's veterans. With their experience and expertise, the VA's medical care personnel are without a doubt the most valuable resource the VA hospitals have.

We appreciate the opportunity to appear before the Committee today to testify on the recruitment and retention of health care personnel within the Veterans' Administration, and to discuss several bills related to the VA's personnel system. During the past few years we have witnessed a growing problem with the recruitment and retention of these personnel, particularly within the field of direct patient care. And unfortunately, this comes at a time of increasing demands on the VA hospital system. As the nation's veteran population ages, they require greater care which means the allocation of more resources to each patient. This includes both technology and direct patient care. But, as the Committee well knows, the Veterans' Administration has been unable to recruit or retain the necessary staff.

We cannot point to just one or two causes for the high attrition and recruitment problems which the agency is currently experiencing. We believe, instead, that their difficulties stem from a series of crises. Proposed and actual budget cuts have severely reduced resources and damaged morale. Just take a look at the Administration's budget request as an example. The Fiscal Year 1988 proposal sought to eliminate funding that would deny hospital care to over 13,000 veterans and would reduce outpatient visits by at least 113,000. The Administration would be better advised to seek increased funding of the VA medical system. Without additional resources, VA hospitals will not remain competitive with private sector facilities in hiring quality personnel.

We also believe that many of the Veterans' Administration's staffing problems are rooted in their outdated and their generally inequitable personnel system. Many VA medical personnel are covered under Title 38 instead of the provisions of Title 5 which cover the rest of the civilian workforce. For example, these medical personnel are not promoted nor are they disciplined in the same manner as their civil service coworkers. Instead, they must submit to highly subjective Peer Review Boards or Disciplinary Boards which often deny employees adequate review or due process. Lacking objectivity and credibility, these Boards are the proverbial "straw that breaks the camel's back". If the lower pay or less generous benefits don't drive employees away, the VA personnel system is frequently the final straw.

There are several bills before the Committee today which indicate your intent to rectify some of the problems which have long plagued the VA medical system. We commend the Chairman and Committee members for your efforts on behalf of the veterans served by the VA and by the emloyees who serve them. While we have concerns about some of these legislative proposals, we commend your efforts to ensure the highest quality of medical care to this country's veterans.

The National Federation of Federal Employees represents medical personnel in Veterans Hospitals throughout the nation. And we are aware of staffing problems of varying degrees in each of these facilities. Whether the hard-to-fill occupation is a registered nurse, pharmacist, or critical care nurse, there is one factor common to all: the VA's compensation and personnel policies have not given the agency the resources to remain competitive in its hiring practices.

Last year, the Veterans' Administration undertook a study of its health occupational staff which confirmed the agency's recruitment problem --- a problem which we have been acutely aware of in the hospitals we represent. I would like to use the VA Medical Center in East Orange, New Jersey as an example of the extent of the staffing dilemna.

The East Orange Center must compete for personnel with numerous hospitals in the area. We looked at several recent editions of The East Orange Star-Ledger newspaper to find out how competitive the VA center is. What we found was a host of advertisements for private sector hospital jobs which offered more flexible work shifts, paid tuition, and better salaries than those offered at the East Orange Medical Center. (I have included a sampling of these advertisements in Appendix 1). While the VA Center offered entry level nurses between $20,378 and $23,207, the same level nurses could earn from $1,500 to $5,000 more at other community hospitals. It is hardly suprising, then, that the VA hospital last year experienced an 18% turnover of registered nurses and a 35% turnover of licensed practical nurses.

High turnover rates translate into greater workloads for the already overburdened employees. As an example, the lack of registered nurses at the East Orange facililty has left the respiratory section understaffed. For nurses who are already physically and mentally overburdened, the prospect of employment at other hospitals becomes increasingly more attractive. We have also heard from our members that the lack of appropriate, modern technology further burdens employees. An outdated record-keeping system, for example, requires valuable time an RN could better employ in direct patient care. Finally, the lack of flexible work shifts contributes to the low morale and high turnover rates.

I believe the solutions to the Veterans' Administration's high attrition rate are as varied as the problems which have caused the turnover. Two bills under the Committee's consideration today seek such a solution. S. 713 would give the Administrator the authority to offer a recruitment and retention bonus to registered nurses in exchange for obligated service. While the idea of offering bonuses to new employees could help address the recruitment problem, it could just as easily create a new one if the bonus is not available to current hires. The VA's most valuable resource is not the RN or LPN who is not yet employed. It is, instead, the experienced worker who is already employed by the agency. It is not clear to me that the bonus authorized under S. 713 would be available to employees currently on the VA payroll. To preclude these medical personnel from such a bonus will only cause resentment and escalate turnover. We would suggest, then, that any bonus be extended to all registered nurses.

While the retention bonus offers one approach to solving the compensation disparity, it does not go far enough in addressing the real problem. VA medical staff are still graded at levels lower than their private sector counterparts. While the recruitment/retention bonus would increase salaries by as much as $6,666, employees must obligate themselves to at least three years of service. If the competition is offering almost as much compensation without the obligatory service, then their jobs still look more competitive.

We believe that higher levels of pay are the solution to the VA's attrition and recruitment problems. Upgrading the positions of medical personnel is the most viable long-term solution. However, in the absence of this option, a recruitment/retention bonus for both new and current employees could help stem the high attrition.

The Veteran's Health Care Act of 1987 offers another approach to attracting and retaining qualified health care personnel, and I would like to comment briefly on this legislation. The bill's sponsors have recognized that the Veterans' Administration must become more innovative in its hiring and personnel practices. We fully support the proposals to give nurses who work on Saturday the same premium pay available for Sunday work. Likewise, we are in favor of opening up the the policy making and fiscal committees at VA medical centers. However, we have several concerns about the remainder of the legislation.

While we support the intent of the bill to provide better compensation to pharmacists and occupational therapists, we question the merit of including them in the "hybrid" Title 38/Title 5 category. NFFE represents many of these so-called "hybrid" employees. We have found that although the category was intended to benefit certain health care personnel, it has instead been used to deny them the rights granted under Title 5. The Veterans' Administration has attempted to cover the "hybrid" employees under the Peer Review Boards and to deny them the right to follow negotiated grievance procedures. Until such time as Title 38 is amended to give employees the same protections available under Title 5, the "hybrid" category should not be extended.

Finally, although we support extending the Health Professional Scholarship Program to physical therapists and establishing a tuition reimbursement program, we question the high penalty which would be applied to employees who cannot fulfill their service obligation. The prohibitive formula elaborated in the Health Care Personnel Act should be replaced with the repayment formula in S. 713.

I would next like to comment on S. 1136, a bill to limit the types of proposed disciplinary actions considered by the Veterans' Administration Disciplinary Boards. Currently, the Chief Medical Director has the authority to appoint such boards to review charges of inaptitute, inefficiency or misconduct of certain VA personnel.

If a disciplinary action is taken pursuant to a charge of misconduct, an employee is precluded from following any negotiated grievance procedures. Instead, he or she may only appeal the action through internal agency procedures. Federal employees covered under Title 5 U.S.C., however, have greater notification and due process rights. For example, before an action (based upon unacceptable performance) may be taken against an employee, that employee has the following rights:

- Thirty days advance written notice on the proposed action,

* The opportunity to be represented by an attorney or other representative,
* A reasonable time to answer orally and in writing to the charges.

urthermore, an employee may appeal such action to the Merit Systems Protection Board.

The Veterans' Administration's Disciplinary Boards are, for the most part, unpopular among the agency's employees who view the Boards as biased and lacking credibility. If the VA is truly interested in improving the disciplinary structure of the agency, we strongly recommend substituting the grievance and appeal mechanisms provided under Title 5, U.S.C., for those provided under Title 38, U.S.C.

In conclusion, Mr. Chairman, I would like to commend this Committee for your concern with the obvious recruitment and retention problems within the VA hospital system. As the Committee works on legislation to correct some of these problems, we would like to extend our assistance and support.

That concludes my statement. I would be happy to answer any questons you may have.

APPENDIX 1 (A)

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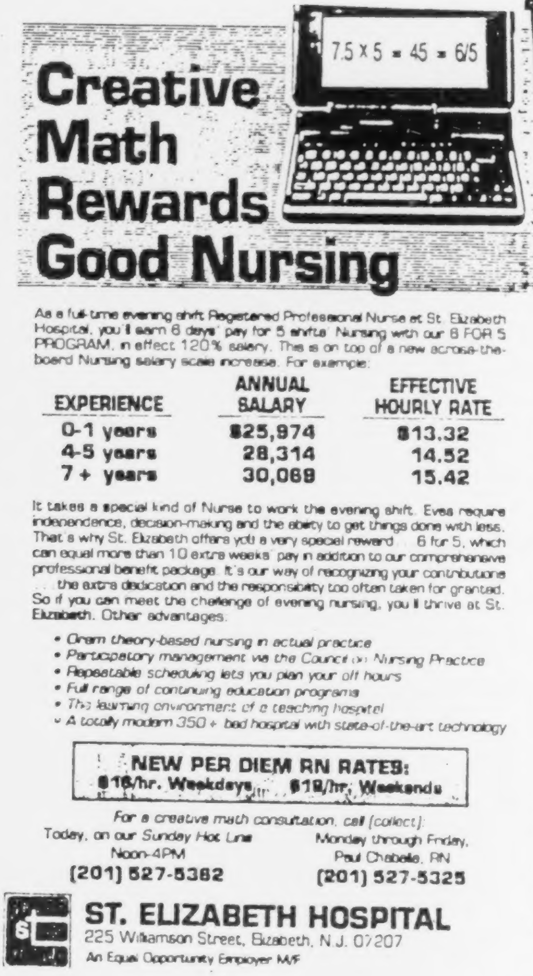
FAVORITE NURSES

APPENDIX 1 (B)



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Statement by Dr. Howard Green, Chief of Staff VA Medical and Regional Office Center on Behalf of the National Association of VA Chiefs of Staff

Mr. Chairman and members of the Committee. I am Dr. Howard H. Green, Chief of Staff of the White River Junction VA Medical and Regional Office Center. I am also a member of the Executive Committee of the National Association of VA Chiefs of Staff and have previously served as that organization's President for three terms.

This testimony represents my personal opinions and where identified by the pronoun we represents what I believe to be (based on discussion with the National Association of VA Chiefs of Staff leadership) those of the NAVACOS membership.

I have been asked to address a number of issues which are as follows:

1. S. 713 which proposes authorization of a bonus for nurses.
2. S. 1136 which changes the types of disciplinary actions in which disciplinary boards should function.
3. S. 1063 which changes the procedure for evaluating probationary employees.
4. S. 1065 which authorizes on-call pay to health care employees employed pursuant to Title 5 or Section 4104(3) of Title 38.
5. Provisions of the Health Care Personnel Act of 1987 (S. 1195) which addresses problems in the recruitment and retention of VA health care professionals.
6. S. 105 which provides incentive special pay for psychologists who obtain certain board certification.
7. S. 631 which requires the standardization of procedures for the procurement of medical and pharmaceutical supplies.

We do not in general favor the bonus approach as a means for solving the nurse recruitment and retention issue. We believe the problem is more complex and this issue should be addressed more broadly. There is no question that availability of both RN's and LPN's and NA's is decreasing nationally. We are therefore faced with two separate but related problems. The first is to compete for nurses in a diminishing supply and the second is to develop a strategy to solve the total supply problem. We will not attempt to address in detail the second issue.

As a matter of principle, salary comparability is required to compete. This comparability means comparability at the local level. National aggregate statistics have little meaning. Previous legislation allowed us to create this salary position. It has suffered in its implementation because: a) response to requests took too long; b) we had to swallow the increased cost from existing budgets; c) once achieved one could not then apply changes in cost of living. Rather, we have to go back through the process of reviewing the special pay rates to establish new rates. I have no problem with this kind of review but this can be done over the longer term. Cost of living increases should be granted to all employees. In short, the legislation was damaged by the implementation strategy. The current administration has moved to change some of this.

When I talk to nurses on my early morning rounds, the following factors are given to me as important to them. This list is the same one given to me by most other Chiefs of Staff with whom I have spoken.

1. The need for flexible schedules. We have to be more internally flexible. I note that Burger King and MacDonalds will tailor work schedules to the worker. We must adapt to requests for 4, 6, 8, 10 12 hour shifts. Management must accept the burden of putting this matrix together.

2. The need for better staffing ratios. Most VA nurses I know work harder than their non-VA counterparts because private sector staffing ratios are better. There must be relief for this.

3. The need to accommodate the special requirements of working mothers. In short, provision of day care, and special consideration for the problem of rotating shifts.

4. A pleasant place on break to put one's feet up and relax. These places should be central to the work area, contain comfortable furniture, have a refrigerator and a microwave and should be nicely decorated and well lit.

5. Provision for educational upgrading. In this particular case we should provide tuition reimbursement for upgrading RN's without degree to the BSN level and beyond. At the White River Junction VAM&ROC we are negotiating with Vermont College, School of Nursing. The plan as put together by our Chief Nurse will be as follows: a) Qualified members of our staff will be given appointments at the school. They will teach clinical courses. b) Non-nursing courses (basic science and humanities will be taught by members of the Vermont College faculty. c) Educational classes will be held at the VA. d) Classes will be timed to accommodate the students. e) Any member of our employee group can start the process of education toward a nursing degree or can take non-nursing courses offered for credit towards another degree. f) There will be no tuition cost to the students.

3.

This plan allows LPN's, NA's, RN's without degrees to accomplish a degree. In addition it allows others to start the process of working toward a degree.

6. Nurses wish to be accepted as valued members of the health care team. They want their opinions to be respected and they wish to participate in hospital decisions dealing with issues of patient care. There is good evidence that when there is harmony between nurses and physicians, patient care and indeed patient survival improves.

Interestingly, all of the factors I have mentioned above have been studied and documented by a task force on nursing practice set up by the American Nurses Association, entitled "Magnet Hospitals: Attraction and Retention of Professional Nurses" 1983. One of the magnet hospitals was the Cheyenne, Wyoming VAM&ROC.

I believe that the provisions contained in the Health Care Personnel Act of 1987 build upon previous legislation and move toward a solution for recruitment and retention of health care personnel. The movement of pharmacists and OT's into Title 38/Title 5 hybrid is a step in the right direction. I also feel that other technical occupations should be considered for this status. For example, laboratory and radiology technicians and perfusionists for the cardiac surgical programs. I also agree with the provisions of the Act which deal with the Health Professional Scholarship Program, premium pay for Saturday as well as Sunday work, and tuition reimbursement for full-time nursing personnel or other full-time health care personnel for pursuit of a degree. I am not convinced that we should include tuition reimbursement for Doctoral Level achievement, since I see no evidence that we have problems recruiting in this area.

It is my opinion that tuition reimbursement is better than the scholarship program because it affects more people. The small numbers affected by the scholarship program does not in my view represent a substantial solution to the problems. The program should be continued, but in my view emphasis should shift to tuition reimbursement.

We are not in agreement with casting into law the requirement that the Chief Nurse or designee be members of VA health care facilities policy making and fiscal committees. I would point out that no such provision exists which require that the Chief of Staff or key Medical Service Chiefs are accorded the same privilege, and I can recall one Hospital Director in the past who did not have the professional staff represented on budget, or position management committees. I expect members who sit on committees which I chair to be looking at the total hospital and not just their own interests. Small committees are preferable to large ones. The statistics presented in the Committee report on this bill shows that some hospitals have not accorded nursing membership of some important committees. It seems to us that this body can make it clear what it feels is reasonable. The gentle art of jawboning can be quite effective. I cannot conceive of a responsible Hospital Administrator or Chief of Staff who would not insist that the Chief Nurse or designee and Chief of Staff be represented on key committees. I would not cast this into law, however.

4.

I alluded earlier to the problem of recruitment in a short labor market versus the problem of addressing the total supply issue. Legislation proposed addresses a good part of the first issue. Unfortunately, legislation cannot change basic managerial attitudes. The Magnet Study previously referenced deals with the importance of these attitudes. The VA must get involved in the total supply issue also. I believe that the plan proposed as detailed above by the Chief Nurse, Mr. Joseph Caldwell at White River, is a step in this direction. I would urge that law allow us maximum flexibility in creating solutions to the supply problem, not only in nursing but in other shortage occupation.

We cannot support the major provisions of S. 1062 which takes the process of judging performance during the probationary period to a higher level than it currently goes. Boards make the recommendation to the Hospital Director who approves or rejects the board action. We believe these decisions should be made at the lowest reasonable managerial level. We agree that recommendations other than termination should be possible.

We support S. 1136 which adds greater specificity to the functions of boards convened for disciplinary actions and to the authority of the Chief Medical Director to delegate appointment of these boards to others. We also agree with the need for boards to deal with proposed removals, suspension for more than 14 days, demotion involving more than 14 days, or demotions involving loss of grade or pay. Protection of the employee for lesser actions can be adequately handled through appeals and grievance procedures. We believe these provisions balance the need for the protection of employees' rights versus the need to have a process which can be handled within reasonable time frames. The current process is so formidable that many actions which should be taken are not.

I agree with S-1065 which authorizes on-call pay to health-care employees employed in Title 5 or Section 4104(3) of Title 38, Despite the fact that many medical centers have employees who agree to on-call without pay except when they are called in; it is my belief that on a systems basis we should rationalize Title 38 and Title 5 on this issue. The cost of doing this at White River Junction VAM&ROC will be approximately $25,000. per year.

We do not agree that (S. 105) incentive special pay is required for psychologists who obtain certain board certification as we are unaware of any problems related to the recruitment and retention of psychologists.

We see a potential problem in S. 631 which requires the standardization of procedures for the procurement of medical and pharmaceutical supplies. We are not opposed to standardization per se because we recognize the cost savings which are possible. We know that the large hospital chains in the private sector have achieved major savings and we are also aware that the Booz-Allen & Hamilton report on the subject of procurement and supply forecasts substantial savings in this area. We are also aware that VA management has addressed this problem quickly and responsibly. There are some hazards if this is cast into law; particularly if the law does not contain flexibility. Let me give you one small example. Over 100 of our hospitals are affiliated. It is important that we do everything possible to have certain supplies such as indwelling intravenous and intra-arterial catheters which are the same as used at the affiliated hospital. The reason is that the residents get used to the characteristics of one set of catheters. In the pressure of critical care medicine, serious mistakes can and are made if the supplies used are not familiar. For example, certain catheters are easily cut off by the needle used to insert them. This can result in a free-floating piece of plastic tubing which migrates into the heart. There are numerous other examples. We feel that since the agency is taking the initiative here it is not prudent or wise to legislate this area.

I wish to thank the Committee for the opportunity to present my views and those of the National Association of VA Chiefs of Staff on these issues.

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

TESTIMONY

of the

AMERICAN NURSES' ASSOCIATION

on

VETERANS' HEALTH

before the

Senate Committee on Veterans Affairs

Presented by

GLORIA S. HOPE, Ph.D., R.N.
DIRECTOR
DIVISION OF GOVERNMENTAL AFFAIRS

MAY 21, 1987

1101 14th STREET, N.W., SUITE 200, WASHINGTON, D.C. 20005 — 202-789-1800

Mr. Chairman, I am Dr. Gloria Hope, Director of the Division of Governmental Affairs of the American Nurses Association, (ANA). I would like to thank you on behalf of the 188,000 members of the American Nurses' Association and its 53 constituent state nurses associations for this opportunity to address veterans' health issues, and health personnel related matters.

As a retired Veterans Administration (VA) nurse, the last ten years of which I served as Deputy Director of Nursing Service, I am pleased to present this testimony for our members, a significant number of whom are VA nurses. In addition, ANA has represented VA nurses in collective bargaining since 1967 through its state nurses associations.

This hearing reflects the committee's in depth perception of nursing's critical relationship to the VA's ability to provide health care to the nation's veterans. It appears from the VA's 1984 pilot program report and the 1986 Survey of Health Occupational Staff that the agency, this committee, and organized nursing all agree that current staffing inadequacies are largely due to difficulties in the recruitment and retention of capable qualified professional nurses.

The U.S. has experienced a shortage of registered nurses at different times throughout its history. Recent reports of unfilled positions in hospitals have led to speculation that we are again facing a registered nurse shortage. A more thorough analysis of the situation shows that the marketplace for registered nurses is changing in response to recent developments in health care delivery.

- The numbers of unfilled positions, particularly in specialty practice requiring advanced education and skills, have increased. This is the result of increased acuity of hospitalized patients and changing demographics, particularly the rising numbers of older Americans. While graduations from nursing education programs have continued to rise, new graduates cannot be expected to immediately function in highly specialized practice areas.
- Increased patient acuity and earlier discharges (the "quicker and sicker" reality of the prospective payment system) have resulted in an increased workload per registered nurse. Because there has been no corresponding increase in pay and benefits accompanying the increased workload, recruitment and retention of nurses, particularly in specialized practice areas, is becoming more difficult.
- More bachelor's degree-prepared nurses are needed. Baccalaureate-prepared nurses are the ones most prepared and most likely to move into specialty areas, such as critical care. The U.S. Department of Health and Human Services predicts a 40 percent undersupply of bachelor's-prepared nurses by 1990.
- The registered nurse population is approximately 97 percent female. Since career opportunities for females have multiplied in recent years, it is more difficult to recruit young graduates into nursing. This shift of the female high school graduates to other career choices is substantiated by recent declines in nursing school enrollments.
- Competition in the new health care market place has produced a wide array of expanding career opportunities for nurses such

as health maintenance organizations, home health agencies, hospices, risk management centers, and entrepreneurial activities. Experienced registered nurses are leaving their positions in institutions to explore these opportunities, which in part accounts for the unfilled positions in hospitals.

RN DATA

Total RN population:	Nearly 1.9 million (1,887,697)
Percentage employed in nursing:	Nearly 1.5 million (1,485,725) or 78.7% of the total (Up from 76.6% in 1980)
Annual average salary of Registered Nurses:	$25,500 - 26,000

BASIC NURSING EDUCATION PROGRAMS

1985 preliminary data compared to 1984 data:

Bachelor's Degree	enrollments down 4.2% graduations up 1.8%
Associate's Degree	enrollments down 7.8% graduations up 1.8%
Diploma	enrollments down 19% graduations down 2.5%

Preliminary 1986 data indicate a deeper decline in fall admissions and enrollments.

Nursing is one of the most sex-segregated job classifications in the country. Approximately 97 percent of all nurses are women. Nursing has traditionally been viewed as women's work and, as such, has been undervalued.

The result is salary compression -- minimal difference between starting salary for a staff nurse employed by a hospital is $20,340; the average maximum salary is $27,744. Given the skill, effort, responsibility, and working conditions of nurses, such compensation is neither attractive enough to lure new recruits, nor competitive enough to retain nurses with years of experience.

The American Nurses' Association is concerned about the unfilled positions created by the change in demand in the health care marketplace. The association is committed to assuring that high quality of health care is maintained, and that there is an adequate supply of well-qualified registered nurses to meet the changing demand in the private sector as well as the VA health care system.

The recruitment and retention of nurses at individual hospitals is only part of the problem. For the first time, almost 80% of all nurses are employed. As we have stated, declining student enrollment increases the problem. Therefore, to increase the pool of nurses available for employment those of us in the health care industry and nursing must increase the opportunity for new recruits into the profession. The VA will not be able to recruit or retain a non-existing professional.

The VA's 1981 study made fifteen recommendations to correct recruitment and retention deficits of nurses, and many are applicable still. We will address several of those: workloads; competitive salaries; benefits; and tuition reimbursement. We will also discuss the vital necessity for nursing participation in executive decision making in planning, policy development, and budget activities throughout the VA health care system. Uniformity and consistency regarding the inclusion of nursing should occur at the Veterans Administration Critical Office (VACO) and at individual facilities.

Impact of the Nursing Shortage

Increased patient acuity and earlier discharges have resulted in a significant increase in the workload per registered nurse. This has created job dissatisfaction. For example, nurses who work in settings where all allocated registered nurse positions cannot be filled are forced to change the way they provide care. They are required to take on an accelerated pace of activities in an effort to stay on top of everything. One alteration in their work style often leads to another; as their workload increases they must set new priorities for the nursing care they give. When nurses have an unrealistic workload, the margin for error increases. Patients may not be monitored as frequently or as thoroughly. Gradual changes signaling the onset of more serious problems may not be immediately recognized. Crisis situations occur that might have been prevented. In addition, psychosocial care, teaching, emotional support and counseling are often omitted.

Providing less than optimal patient care often results in low morale and a sense of dissatisfaction. When vacancies exist, hospitals also resort to mandating that nurses work extra hours, i.e., double shifts and their assigned days off duty. For example, it has been reported that nurses in one hospital, work as many as five double-shifts a week. This exploitation of limited manpower has prompted many nurses to express concern regarding patients' welfare and to question the quality of care being delivered. Ultimately they become exhausted, disillusioned and burned out. Some leave the nursing profession at this point. Because no sufficient adjustments in pay and benefits have occurred to compensate for the increased workload and the highly sophisticated and highly technical nursing care required, retention and recruitment, especially in specialized practice areas, becomes more difficult.

VA hospitals are over 8000 nurses below their own.staffing guidelines for nursing personnel. ANA members working for the VA nurses in areas such as East Orange, New Jersey, Washington, D.C., and Texas report nursing shortages of 65-80 per hospital. The result is critical care units with increased patient per nurse ratios, and coronary intensive care units that are staffed with outside agency nurses who make $18-$24 an hour, which is more than in house VA nurses earn. Operating room nurses and non-clinical staff in continuing education are placed on medical-surgical units and in "step down" areas to cover for inadequate clinical staffing.

Morale is even lower when nurses cannot attend in house training programs because they cannot leave their unit due to minimal staffing. Some nurses report that attendance at outside professional educational advancement programs cannot occur even when the individual is willing to bear the cost as administrative or annual leave is not granted because of staffing concerns.

In the 1970's the VA attracted nurses by stressing the professional, educational and research opportunities within the system. If nurses cannot participate in those activities because of decreases in access due to budget, staffing, and scheduling they will go elsewhere to pursue their professional interests and needs. Can you imagine a recovery room nurse who is past due on her annual CPR certification because she has had to cancel attendance at several training sessions because she cannot leave the unit? How can the VA assure up to date professional standards of care when such occurrences are happening at facilities with increasing regularity?

S. 713

The purpose of S. 713 is to facilitate recruitment of nurses by providing a bonus of up to $20,000 to nurses who agree to the provisions of employment. We have been told the bonus is not intended to be limited to recruitment, but could also be offered for retention.

ANA believes that bonuses are short term solutions. They attract people initially, but if the problems of inadequate staffing and job dissatisfaction persist, the recipient leaves after fulfilling her obligation. As this bonus is discretionary, we question whether it will be generously offered. Effective implementation of the bonus program is accompanied by the same difficulties exhibited in the existing special pay programs. Determination of significant problems in recruitment and retention of registered nurses in specific geographic location and professional specialties could be so time consuming as to be effectively non-feasible.

It is also not difficult to imagine nurses threatening departure or actually terminating employment at one VA to qualify for the bonus at another VA. We do not believe that the bonus is a viable option for retention of tenured VA nurses, and fear that it will create morale problems.

ANA has historically supported the VA Health Scholarship program and urges its continuation and continued funding. In the first year of the program, 3000 nurses applied for awards. Since 1983, over 2000 applicants have sought scholarships. In 1983, 341 were funded, in 1984, 205 were funded, and in 1985, 195 were funded. The amount of the awards depends upon the schools attended and the length of the award.

It is estimated that the $4.5 million for nurses proposed in FY 88 budget will fund 198-240 nurses. The record of the past health scholarship program thoroughly substantiated the benefit it was intended to produce. As of March, 1986, of those who have completed the program, 109 have continued with the VA and only 11 have left after their 2 year service obligation.

Special pay authority has been in effect for approximately 92 medical centers for several years. However, special pay authority has not been successful in recruiting the numbers of nurses needed by certain VA facilities. Although the VA has authority to grant special pay for documented recruitment and retention problems, funds must be designated and available to local VA Directors to compete with the private sector. Currently, if special pay is to be allocated, it must come from an existing source of funds, rather than new money. Therefore, if directors must deplete other programs, the special pay authority is meaningless. The length of time required to fulfill an individual facility's request is also problematic, and the centers have been unable to respond quickly to changing marketplace forces. Finally, the failure of the VA to award the Federal Employee Cost of Living Adjustment to nurses on special pay adds an additional burden to the procedure.

We believe that if junior grade nurses at 92 hospitals receive special pay which places them at the top scale, perhaps a better strategy would be to delete junior grade. Entry positions could be restructured at the associate level to accommodate a new starting salary for nurses.

S. 1065

S. 1065 authorizes "on call" pay to certain civil service health care personnel. We support the agency's efforts to assure adequate staffing for medical emergencies. Title 38 presently authorizes "on call" pay to RNs, and this bill further removes inconsistencies between Title 38 and 5 employees where duty requirements are similar. The existing provision was inequitable as to physical confinement for Title 5 employees and penalized professional nurses by paying them less for "on call" than "standby" Title 5 employees.

S. 1195

ANA is pleased that S. 1195 proposes several options that nursing has long advocated. As we have stated, we endorse the VA Health Scholarship Program. We would suggest that the obligated service be a minimum of two years, with one additional year for each year of support. Payback should not be viewed as so burdensome that it inhibits enrollment in the program. Although we recognize the budget concerns which necessitate priority for senior applicants, disciplines other than nursing are not so restricted. Additionally, a review of present scholarship applicants indicates that 66 to 75% of them are juniors. Senior priority criteria could decrease the qualified applicant pool to one out of ten. Similar programs at the Public Health Service initially apply to second year applicants.

Although the bill for the first time authorizes tuition reimbursement, we are disappointed, that as a clone of the existing scholarship program, it will not accomplish what is purports to do. As the American Organization of Nurse Executives (AONE) indicated in their 1985 study, 80% of surveyed hospitals offered tuition assistance as a benefit for full time employees. The VA itself acknowledges that 77% of its facilities believe tuition assistance would be a major advantage in recruitment and retention.

ANA has major concerns regarding the selection of applicants for the tuition reimbursement program. The bill sets the program ostensibly as a merit reward or bonus. Priority is given to nurses with superior proficiencies as determined by the facility's Chief Nurse in consultation with the local career development committee. We believe any nurse who meets her qualification standards should be eligible without consideration of such subjective criteria. The application of employment evaluation criteria and external committee determination requires excessive administrative involvement. We recognize that those unfamiliar with employment tuition reimbursement plans may overestimate the costs by envisioning the VA's total nursing force requesting such reimbursement. Estimates indicate that only 10% of the eligible nurses will avail themselves of the program. We suggest the VA make a reasonable cost estimate for the program, and request sufficent funds to realistically compete with the private sector. Too restrictive an application process for the tuition reimbursement program will render it ineffective. We urge the committee to reconsider the program, and designate it as an entitlement.

ANA endorses the provision for Saturday premium pay. Hospitals almost universally offer additional pay for weekend staffing. A hospital of the VA's size and status is out of line with the private sector. Such pay is especially important when nurses only receive one weekend off out of three weekends. The VA is at a disadvantage when the private sector provides every [illegible]er weekend off for full time nurses. During the week VA nurses are overworked because of inadequate staffing and increased work loads. Weekends increase the nurse's responsibility because of decreased staffing in other hospital departments and changes in staffing schedules. It is illogical and inequitable to offer less pay for Saturday duty under those circumstances.

S. 1062

ANA has no objections to S. 1062, which clarifies the authority of the Chief Medical Director regarding disciplinary actions on certain probationary Title 38 health care employees. Regulations prescribed by the administrator would assure consistency regarding employee performance reviews during probation.

S. 1136

This bill would limit the types of proposed disciplinary actions and delegation of the Chief Medical Director's authority. We have major concerns about certain aspects of the bill. The bill purportedly would decentralize a time consuming and legalistic process. Indeed, we believe that centralization is necessary to provide consistency and guarantees due process.

ANA believes that the disciplinary process should not make a distinction between seriousness of offenses. The proposed bill compromises the concept of a progressive disciplinary system. We do not believe that an employee's rights to due process are any less when lesser disciplinary actions are involved. It is the degree of penalty, not the extent of due process which properly fluctuates with the seriousness of the infraction. Additionally, the employer often relies on a chain of lesser actions as a reliable indication of a more serious disciplinary problem which needs correction. Therefore, the employee must have a meaningful opportunity to challenge those "lesser" actions as they may become the substantive basis for later penalties. If the employee is denied due process on the lesser actions in the chain, she could be precluded from challenging their effect on more substantive actions, such as a discharge action.

Although a written reprimand does not carry the same immediacy as a discharge for an employee, the issue of truth exist for both serious and minor infractions. It must first be established there has been an infraction and then a fair penalty imposed after proof is determined. The VA has recognized the employees legal interests in statute and must consider what revisions could lessen administrative time burdens but preserve employee due process.

In closing, ANA reiterates its commitment to assuring quality nursing care to our nation's veterans. As a profession, nursing has always responded to a health care crises and we pledge to cooperate with the VA to provide the nurses necessary to operate the VA health system. We hope that these hearings culminate a committed collaborative effort to maintain the ability of the VA to provide quality health care. Thank you again for the opportunity to present ANA's concerns and recommendations.

NAVAP
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TESTIMONY OF

PETER HAWLEY, M.D.

PRESIDENT

NATIONAL ASSOCIATION OF VA PHYSICIANS (NAVAP)

at the

HEARING REGARDING VETERANS' HEALTH AND HEALTH-RELATED PROGRAMS

before the

SENATE COMMITTEE ON VETERANS AFFAIRS

MAY 21, 1987

My name is Peter Hawley. I am a physician, my specialty being clinical pathology, and I am also a veteran. I appear here today in a strictly unofficial capacity in respect to the Veterans' Administration as the President of the National Association of VA Physicians (NAVAP). I speak on behalf of the Veterans Medical Program and all those health care professionals who serve therein.

I attended medical school and did my residency in Anatomic and Clinical Pathology at the State University of New York Upstate Medical Center, Syracuse where I spent part of my training time in the VA. Then after three years in the United States Army I started at the VA Medical Center here in Washington as the Pathologist in charge of Microbiology and Immunology. I have served full-time in that position since 1978. My academic identification is as Assistant Professor of Pathology at the George Washington University.

In the almost nine years I have served at the VA I have seen a continual erosion in our ability to attract talented, industrious men and women to fill jobs serving our veteran patients. Bench level laboratory technologists, who are Title V employees, have left to go into private hospitals across the street to earn more money than their VA supervisors. It is no longer uncommon to have technologist positions vacant for months or even longer than one year. Secretarial and clerical positions can be even more difficult. In spite of very genuine attempts at recruitment by the Medical Center Administration and recruitment we usually must hire marginally trained people who leave for better paying jobs after only two or three months while acquiring their training on the job.

The situation becomes an outright disaster in respect to Title 38 employees. The shortage of nurses is so acute that we are actually closing down whole wards and curtailing many essential functions. While it is true that we are still able to recruit young physicians just out of residency training, we can't keep them. Many stay with us only long enough to study for their board examinations and then quickly leave for what they perceive to be the greener pastures of academia or the private sector.

Mr. Chairman, NAVAP welcomes and encourages any attempt to promote the hiring and long term retention of skilled professional personnel by using scholarship programs, pay for on-call services, and bonus pay for extended service commitments. Hopefully these will help build a cadre of highly committed professional personnel to serve our veteran patients' needs. It appears to us that S.1065 would reduce Title V employee payments to the level of Title 38 when in fact Title 38 employees should be remunerated at the same rate as now prevails for Title V.

But you can be sure that doctors, nurses, and other Title 38 personnel have heard horror stories as to the way their predecessors have been treated. Why make a career commitment, become captive to the system by many years of service, and then suffer a similar fate.

Not forgotten is the Holiday surprise of December 1981 when P.L. 97-72, without a grandfather provision, changed the formula for calculating annuity benefits. This took away tens of thousands of dollars from hundreds of nurses and doctors who in good faith had planned their entire professional lives on a set of retirement rules now cancelled retroactively.

Also not forgotten is the arbitrary and capricious 1982 decision by then-Administrator Nimmo to take away $5,000 of VA physicians' Special Pay. Though part of this loss has been recovered, each year each VA physicians still loses $2,682. This irrationality cannot leave a favorable impression on young VA doctors as they earn promotions only to find out that they earn less. NAVAP tried without success to correct these anachronisms in the courts. It is still possible of correction legislatively.

Morale among our health care workers is adversely effected by many other factors:

It is clear for all to see that the present Administration's attitude towards federal employees is less than that of a warm friendship.

Privatization of veterans health care is perceived by many as a real threat. And why not? We see McDonnell Douglas well on the way to taking over our data processing capability. Can the Hospital Corporation of America, National Medical Enterprises, or other giant corporate health-care-for-profit organizations be far behind?

Our Health Care Delivery System may literally self-destruct under the weight of its own managerial and administrative burden, which has already grown to obscene proporations.

It does not go unnoticed that Agency leadership over the last few years has been somewhat less than stable. In the span of five years we have had three Administrators and three Chief Medical Directors. Each brings a new style, priorities, and management team. Thus we have had to cope with the changing emphases of MEDIPP and DGR-RAM and with other acronymed-programs on the horizon.

Many ask the question, "Where does the money go?". The Congress regularly appropriates veterans medical care funds in excess of the President's budget and generally in the order of the Agency's identified current services requirement. Yet at the facility level we have inadequate supplies. And we are seeing sharp staff curtailment often orchestrated secretly and cynically by Byzantine cabals. We have recently begun to function under a directive greatly curtailing beneficiary travel. This is a most cruel way to cut expenses. They see the 100 mile exemption as a penalty over which someone, somewhere must be gloating. It surely is not appreciated how many of our veteran outpatients will not be able to afford to come to our clinics.

The Agency's quasi-military personnel system is itself the cause of much disenchantment. An individual quickly finds out how few rights one really has when the Agency itself is prosecutor, judge, and jury.

Any attempt to codify and expand the rights of Title 38 employees for grievance to adverse actions are most welcome. There are few recourses opened to this class of VA employees when compared to their Title V counterparts, especially those in part-time status. NAVAP would fully support review by disciplinary boards of all adverse actions which would curtail the clinical privileges of physicians. The Agency would have us believe that only changes resulting in demotions with loss of pay, long suspensions, or removals should be subject to review by disciplinary boards, but let me assure you that the loss of the ability to fully practice one's specialty is a far greater penalty than a suspension for a few weeks. Skills that take years to develop must be continually nurtured to remain sharp.

We would also question the wisdom of delegating the authority to appoint the disciplinary board back to the local level. I have already mentioned that Agency functions as prosecutor, judge, and jury. If this authority is delegated back to those who may have leveled the charge in the first place, then we can add accuser to that list. One can hardly claim that due process is served under these circumstances, but rather that this becomes a mockery of the review system. Until all review or appeals of disciplinary actions are removed from the precincts of the Agency and are put in the hands of a truly impartial body, we must conclude that VA physicians remain subject to capricious or vindictive actions by the Administration. Also, we do not look with favor on the creation of yet another Board to review VA physicians who have successfully completed their probationary period. We already have too many Boards.

If we are truly interested in first quality health care for our veterans, I suggest the following actions be taken:

Discriminatory grandfathering differences between Title 38 and Title V annuity calculations must be eliminated.

The continuing $2,682 reduction in VA physician special pay should be stopped.

The present Administration's attitude toward federal employees probably cannot be changed but the turning back of McDonnell Douglas' aggressive takeover effort would send an appropriate message to America's health-care-for-profit corporate giants.

The Agency should be required to document the last decades changing number of administrative personnel as compared to those of us who actually take care of patients.

Monetary and other creative inducements must be increased well beyond current levels, you only get what you pay for.

The Agency's handling of disciplinary action must be examined and revised to truly protect employees from capricious and vindictive action.

And why not get the answer to the question, "Where does the money go"? Is it diverted or wasted as it goes through the Central Office hierarchy, to Regions, to Districts, to Facilities, and finally to its only reason for being: namely, to take care of our veteran patients.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

TESTIMONY

May 21, 1987

To The

Committee on Veterans' Affairs

United States Senate

Senator Alan Cranston, Chairman

Statement pertinent to S-6 and S-216 to Amend Title 38, United States Code, to increase the per diem rates paid to states for providing care to veterans in State Homes.

Prepared By:
Jack J. Dack, Chairman,
Legislative Committee
National Association of
State Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

Nations who engage in war have found that one of the inevitable costs of engaging in war is the care of those who were injured in combat or those who were disabled after combat. Such legacy dates back to the 16th Century in London and Paris. In America, the national government assumed responsibility for care of needy servicemen in the 1800's, particularly after the Civil War. A number of states, too, took steps to establish homes for the domiciliation of disabled soldiers and sailors. The State Homes were erected and operated entirely at state expense.

In 1888, the federal government established the first grant program in American history, thus appropriating funds to State Homes ($100 per year, per veteran) to assist them in their costs of providing care and treatment. Subsequent legislation increased the per annum rates and expanded the program in 1949 to include State Home hospital care.

In 1960, the method of federal aid payments to State Homes was changed from a per annum rate to a per diem rate by the passage of PL 86-625. A per diem rate of $2.50 was established in both domiciliary and hospital care. In 1964, PL 88-450 authorized the nursing home care program within the Veterans Administration, expanding the per diem program in State Homes to include a rate of $3.50 for nursing care. Again, subsequent legislation increased the per diem rates with the latest increase and present rates authorized by PL 98-160, effective April 1, 1984. The current State Home per diem rates are $7.30for domiciliary care, $17.05, for nursing home care, and $15.25 for hospital care.

Much discussion over the years has evolved around what is the appropriate level of participation by the federal government or the adequate level of per diem payments to State

Homes. In its report on the 1976 increase in per diem rates, the Senate Committee on Veterans' Affairs stated that the increase would "keep the federal proportionate share of operating costs at levels consistent with the average federal proportionate share during the past five years, approximately 30%." In SER 98-1, Hearing before the Subcommittee on Hospitals and Health Care of the Committee on Veterans' Affairs, House of Representatives, Ninety-Eighth Congress, First Session, February 16, 1983, page 30, under Mr. Penny references a "historical standard" of established commitment to support the Homes. The federal participation in the cost of veterans' care in State Homes (1978-1986) has ranged from a high of 28% in 1978 to a low of 18.7% in Fiscal Year 1983. (Exhibit A, Copy of 1978-86 costs).

Title 38, U.S. Code, Section 641, amended by Public Law 98-160, Section 105, requires "the Administrator shall submit every three years to the Committees on Veteran Affairs of the Senate and the House of Representatives a report on the adequacy of the rates provided in Subsection (a) of Section 641 in light of projections over each of the following five years of the demand in the Veterans Administration for the provision of nursing home care to veterans eligible for such care under this Section and Sections 610 and 620 of this Title."

The initial report of June 30, 1986, received by the Committees deals only with the discussion of the nursing home care level of care. The State Homes are also involved in providing domiciliary and hospital type care. During Fiscal Year 86, the State Home program provided 4,679,406 days of care -- 1,570,713 domiciliary, 2,922,695 nursing home care, and 185,998 hospital days of care for an average of 12,891 veterans daily. (Exhibit B, FY 86 Report).

We in the National Association of State Veterans Homes are interested in the adequacy of the per diem rates for all three levels of care. With this in mind, the National Association of State Veterans Homes over the years has developed per diem increase proposals based on a thirty percent participation ratio. Such a proposal incorporating the every three year review of per diem rates as mandated in Title 38, United States Code, was updated and forwarded to the Committees December 11, 1986, for consideration (Exhibit C). On April 30, 1987, a proposal to anchor State Home rates based on a thirty percent participation rate paid to States to the previous year per diem costs of care provided in Veterans Administration facilities was submitted to Senate Veterans' Affairs staff as a recommendation (Exhibit D). Despite our effort in this endeavor, to date we have not been successful in accomplishing our goal.

We in the Association once again strongly recommend the per diem rates for State Veterans Homes be reviewed and adjusted on an annual basis like the other Veterans Administration long-term care programs -- Community Contract Nursing Homes and funding for the Veterans Administration nursing home care programs (Exhibit E). We strongly urge that our per diem rates be anchored to Veterans Administration costs at the thirty percent level.

It is felt this is a critical issue if states are going to continue to be a viable, cost-effective alternative to provision of long-term health care services for this nation's elderly veterans.

Published comments on the draft of the Executive Order, 1987 Budget, indicated a proposal calling for a "new long-term care policy," emphasizing the use of community nursing homes and State Veterans Homes rather than additional federal facilities.

With a 10 percent shift in provider mix for State Veterans Homes, it is important that the per diem rates which are prescribed by law reflect the same consideration. (State Homes-20% to 30%; Veterans Administration 30% from 40%; Community Contract Nursing Home Care 40%). In order to meet this goal the State Home Program is going to have to provide an additional 382,309 days of nursing care. This figure is based on the Fiscal Year 1986 days of nursing home care provided within the Veterans Administration Nursing Care Units.

The State Home Program has for years proven itself a high quality, cost-effective alternative to the direct provision of care in federal facilities, a fact which the Executive Order in the Budget seemed to recognize. However, this recognition comes at a time with the ever-continuing rise in health care costs, when several state home facilities are dealing with hiring freezes, budget cuts and similar restrictive measures reflecting fiscal problems being encountered by many states. It is noted that the operating expenditure of the State veterans Home Programs for Fiscal Year 1986 was an increase of 7 percent over 1985. (Exhibit A) According to the Consumer Price Index, February 1987, Medical Care Services, U.S. City Average, the national inflation rate in health care services was hovering around 7.3% appearing to remain at this level.

Continuation of the current per diem rate being reviewed every three years will be seen as a further disincentive to both the full operation of existing state home facilities and the creation of the needed additional beds to meet the 10 percent provider shift mix in order to accommodate the large and rapidly aging population of Word War II veterans now coming into our facilities in significant numbers.

S-216 and S-6 introduced in the Senate reflects specific per diem rates for which the Association is grateful and supports. We appreciate the continued interest and support by the Committee for the State Veterans Home Program.

Such rates in the short run will increase the present federal per diem reimbursement participation. When analyzed compared with the projected average increase in the per diem costs within the State Veterans Home Program, a downward trend is noted following implementation. (Exhibit F).

We observe that all rates are well below the 30 percent target share. Further, the just published Veterans Administration "Guide for Inspection of State Veterans Homes: Domiciliary Care Standards," carries a strong potential for adverse impact on the cost of operations of many State Home domiciliaries.

It is important to note the role which the State Home Program plays in the overall scope of long-term care provided to veterans. The Veterans Administration nursing home units are increasingly focusing their efforts on the short-term rehabilitation of hospitalized veterans. Care in community contract homes is normally limited to a period of six months with some options for renewal. The care furnished by the state veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need for receiving nursing care over a protracted period of time, thus placing the state homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period.

This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG's) concept of providing care in community acute care facilities and recently implemented in the Veterans Administration Medical Centers. Without an adequate federal reimbursement structure for the states sponsoring State Veterans Homes, the expansion and/or full utilization of present capacity required for this long-term nursing care will not exist at that precise time in history when it is most critically needed.

Thank you, Mr. Chairman and members of the Subcommittee for permitting the National Association of State Veterans Homes to present its views on this important legislation.

Jack J Dack

Jack J. Dack, Chairman
Legislative Committee
National Association of
  State Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158
May, 1987

EXHIBIT A

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

State Veterans Homes
Domiciliary, Nursing Home and Hospital Care

Fiscal Year	Days of Care	Inflation Factor	Total Veteran Cost	Grant In Aid By V.A.	Percent of V.A. Participation
1978			$119,787,476	$33,650,314	28.09%
1979			$130,407,587	$34,690,318	26.60%
1980			$150,381,021	$35,210,938	23.41%
1981			$184,477,902	$40,743,234	22.09%
1982			$207,898,345	$41,616,923	20.02%
1983	4,359,648		$230,183,790	$43,185,424	18.76%
1984	4,554,179	8.25%	$260,951,051	$52,920,076	20.28%
1985	4,634,293	6.42%	$282,592,321	$63,154,842	22.35%
1986	4,679,406	7.17%	$305,789,146	$63,366,998	20.72%

V.A. Federal Grants Applicable to Domiciliary, Nursing and Hospital Care provided by State Homes Office Assistant Chief Medical Director for Geriatrics and Extended Care, DM&S, Veterans Administration, Washington, D.C.

Unaudited totals

5/21/87

EXHIBIT B

VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND HOSPITAL CARE PROVIDED BY STATE HOMES

DOMICILIARY CARE   39 WITH 3 ANNEXES   FY 1986

COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME

	VETERAN DAYS OF CARE	AVERAGE DAILY CENSUS	AVERAGE COST PER DIEM	TOTAL VETERAN COST	GRANT-IN-AID BY VA	PERCENT OF COST
TOTALS	* 1,570,713	4,303	* $40.46	$63,552,120.72	$11,377,653.25	17.90%
AR Little Rock	36,053	93.5	28.50	970,510.50	248,506.00	25.61%
CA Yountville	233,771	640.3	49.02	11,459,456.42	1,706,520.10	14.89%
CO Homelake	28,361	76.0	23.71	682,285.11	109,186.50	16.00%
CT Rocky Hill	117,326	323.2	30.44	3,571,403.44	856,479.80	23.98%
GA Milledgeville	62,903	172.0	50.00	3,087,677.00	656,271.90	21.25%
ID Boise	29,875	82.0	30.13	900,133.75	218,007.50	24.22%
IL Quincy	34,003	95.3	46.00	1,563,814.30	252,801.00	16.16%
IN Lafayette	29,050	80.2	64.00	1,859,200.00	212,065.00	11.41%
IA Marshalltown	36,334	100.0	38.72	1,406,852.48	265,237.50	18.85%
KS Fort Dodge	25,605	69.0	28.00	731,664.00	185,486.50	25.35%
LA Jackson	27,421	75.3	34.03	912,045.43	201,455.30	22.11%
MD Charlotte Hall	17,537	50.5	36.32	636,943.04	128,028.10	20.10%
MA Chelsea	97,209	266.5	21.93	2,132,136.00	710,003.70	33.30%
MA Holyoke	10,605	29.0	25.57	271,169.85	77,416.50	28.55%
MI Grand Rapids	50,073	139.5	29.00	1,479,308.04	373,372.00	25.10%
MI Marquette	30,206	83.0	59.38	1,793,633.30	220,510.60	12.29%
MN Hastings	67,540	186.0	31.61	2,168,647.40	493,042.00	22.73%
MN Minneapolis	65,459	179.0	25.23	1,651,510.57	477,056.70	28.89%
MO St. James	11,992	33.0	26.80	321,385.60	87,541.60	27.24%
MT Columbia Falls	22,251	61.0	27.30	607,407.30	162,431.00	26.74%
NE Grand Island**	41,909	115.0	40.24	1,686,032.56	306,273.70	18.16%
NJ Menlo Park	13,376	37.0	41.11	546,087.36	97,644.00	17.70%
NM T or C	3,783	10.7	21.60	81,712.00	20,221.00	24.75%
NY Oxford	21,562	59.5	109.17	2,353,823.54	157,402.00	6.69%
ND Lisbon	36,632	101.5	27.82	1,018,902.24	200,250.00	19.65%
OH Sandusky	91,020	251.0	38.32	3,488,114.33	664,609.90	19.05%
OK Ardmore	19,076	55.0	56.50	1,083,707.00	105,167.00	9.70%
OK Clinton	9,516	27.5	47.33	450,400.94	53,423.15	11.86%
OK Sulphur	6,161	16.0	44.50	275,393.50	49,120.00	16.30%
PA Erie	25,352	68.0	74.03	1,876,555.04	183,755.00	9.79%
PA Hollidaysburg	61,962	166.0	50.79	3,149,034.90	440,461.00	13.41%
RI Bristol	15,603	43.0	52.56	820,061.33	113,083.90	13.79%
SD Hot Springs	22,251	61.0	32.71	727,895.63	163,444.90	22.32%
VT Bennington	7,150	20.0	27.07	186,410.50	52,195.00	26.57%
WA Orting	21,503	59.0	46.00	1,004,293.60	180,964.00	18.60%
WA Retsil	40,009	111.7	43.00	1,750,037.00	307,183.70	16.90%
WV Barboursville	64,283 *	160.0	27.30	1,488,040.34	308,365.90	20.70%
WI King	34,709	95.5	45.13	1,570,027.57	253,959.70	16.16%
WY Buffalo	* 10,083	57.0	47.10	820,250.20	185,810.50	22.31%

Corrected Average Cost Per Diem

* $ 48.46

OK. Norman - contains 6 Domiciliary Beds.

*Grand Island - State Home with Annexes.

NURSING CARE TOTAL   43 WITH 3 ANNEXES

COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME

	VETERAN DAYS OF CARE	AVERAGE DAILY CENSUS	AVERAGE COST PER DIEM	TOTAL VETERAN COST	GRANT-IN-AID BY VA	PERCENT OF COST
	3,023,695	8,284	* $68.43	$206,916,089.37	49,173,906.69	23.76%
CA Yountville	237,032	652.0	94.70	22,544,095.30	4,055,045.00	17.99%
CO Florence	29,627	79.2	55.00	1,642,026.00	501,730.35	30.56%
CO Homelake	6,425	18.0	48.45	311,201.25	142,646.25	46.15%
GA Augusta	64,038	179.0	73.30	4,692,976.44	1,105,437.90	23.56%
GA Milledgeville	78,265	215.5	110.39	8,639,673.35	1,334,010.25	15.45%
ID Boise	28,754	78.5	58.62	1,685,559.48	378,632.43	22.46%
IL Quincy	141,501	389.5	63.86	9,036,253.86	2,412,502.05	26.70%
IN Lafayette	98,006	270.2	65.98	6,466,435.88	1,672,025.30	25.85%
IA Marshalltown	171,095	473.5	84.19	14,404,001.00	2,930,608.75	20.35%
KS Fort Dodge	22,074	61.0	41.40	913,863.60	376,361.70	41.18%
LA Jackson	44,954	123.2	49.26	2,214,434.04	766,465.70	34.61%
ME Augusta	36,333	100.7	67.05	2,436,127.65	610,477.65	25.05%
MD Charlotte Hall	11,470	47.0	67.50	774,165.00	195,609.90	25.26%
MA Chelsea	19,530	53.5	39.84	778,048.32	332,952.40	42.79%
MA Holyoke	91,442	252.0	70.52	6,448,489.04	1,559,006.10	24.18%
MI Grand Rapids	180,640	563.2	78.00	14,043,712.00	3,306,812.00	24.00%
MI Marquette	29,050	82.5	83.47	2,424,652.50	510,667.50	21.06%
MN Minneapolis	111,511	307.0	53.21	5,933,500.31	1,901,262.55	32.04%
[illegible]	33,366	91.7	60.34	2,013,703.04	568,710.00	28.26%
MO Mount Vernon	34,206	94.2	50.92	1,741,740.70	504,235.30	28.94%
MO St. James	55,520	152.7	50.31	2,793,513.06	760,068.00	27.69%
MT Columbia Falls	21,209	58.2	51.26	1,087,173.34	361,613.05	33.26%
NE Grand Island**	180,716	495.0	57.46	10,383,961.36	3,001,207.00	28.87%
NH Tilton	31,065	87.5	58.14	1,804,090.10	543,200.25	30.11%
NJ Menlo Park	114,812	315.2	66.40	7,623,757.70	1,753,629.60	23.05%
NJ Vineland	94,445	260.5	81.43	7,690,656.35	1,910,287.25	24.84%
NM T or C	8,392	23.0	49.97	419,360.20	101,004.30	24.09%
NY Oxford	23,405	65.0	132.05	3,087,064.75	400,509.75	13.07%
OH Sandusky	95,616	262.0	54.70	5,230,050.38	1,636,015.00	31.10%
OK Ardmore	49,473	136.7	64.72	3,201,092.06	843,514.65	26.34%
OK Clinton	45,739	124.6	76.33	3,488,003.07	779,049.95	22.37%
OK Norman	64,440	170.3	67.14	4,327,038.72	1,090,010.40	25.20%
OK Sulphur	50,515	138.2	70.40	3,556,355.40	861,200.75	24.21%
OK Talihina	56,433	155.2	72.19	4,074,049.06	962,033.18	23.61%
PA Erie	35,005	70.5	104.50	3,658,064.15	439,075.20	12.72%
PA Hollidaysburg	69,300	191.0	92.60	6,417,002.16	1,162,553.00	18.23%
RI Bristol	94,062	260.7	76.02	7,150,244.56	1,619,545.10	22.65%
SC Columbia	53,382	146.2	62.96	3,361,078.04	708,336.95	21.51%
SD Hot Springs	10,140	28.0	55.10	558,748.00	159,028.96	28.46%
VT Bennington	43,753	118.5	84.70	3,705,916.47	733,030.65	20.12%
WA Orting	70,043	190.0	70.00	2,940,071.40	600,583.15	16.38%
WA Retsil	60,423	165.8	65.70	3,969,701.18	1,030,212.15	25.95%
WI King	166,103	463.5	76.54	11,109,613.22	3,493,390.63	31.20%

* $ 71.48

IL. Manteno - was recognized as a State Veterans Home by the Veterans Administration on July 7, 1986. Per Diem Grant in Aid was $149,009 based on 8,700 Days of Care for 1986. These figures are not included in the totals.

** Grand Island - State Home with Annexes.

EXHIBIT B
Page 2

HOSPITAL CARE TOTAL

	COST [illegible] BY VETERANS ADMINISTRATION & VETERANS HOME					
	VETERAN DAYS OF CARE	AVERAGE DAILY CENSUS	AVERAGE COST PER DIEM	TOTAL VETERAN COST	GRANT-IN-AID BY VA	PERCENT OF COST
	185,898	640	$223.66	$33,320,527.73	2,816,438.50	8.45%
CA Yountville	10,305	28.5	$87.01	8,990,601.05	[illegible],505.75	2.14%
CT Rocky Hill	113,281	310.5	130.94	15,852,543.14	1,736,762.50	10.96%
IL Quincy	5,302	14.5	215.79	1,144,118.58	80,717.75	7.06%
IA Marshalltown	7,358	20.2	164.19	1,208,118.02	112,209.50	9.29%
MA Chelsea	63,007	120.2	101.31	6,025,000.47	660,056.75	8.32%
MA Holyoke	5,012	14.0	203.34	1,019,140.08	76,433.00	7.50%
OK Sulphur	1,033	3.3	69.83	72,136.39	15,753.25	21.84%

* $179.14

KEY:

Column 3 - Average per diem cost - The State Home per diem is based on the cost of operation divided by the total days of patient (veteran-non-veteran) care during the fiscal year. The average per diem cost is the total veteran cost divided by the total veteran days of care.

Column 5 - Grant in Aid by VA - The per diem rates for 1986 were $7.30 for domiciliary care, $17.05 for nursing home care, and $15.25 for hospital care.

Note: Cost figures are unaudited

* Memorandum 2/11/87, ACMD, Geriatrics and Extended Care (18) Veterans Administration, Washington, D.C.

5/21/87

5/21/87

EXHIBIT C

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

COMPARISON OF VETERANS ADMINISTRATION AND STATE HOME ACTUAL COSTS, PER DIEM PAYMENTS AND ESTIMATED COSTS

FOR THE YEARS ENDING SEPTEMBER 30, 1984 - 1990

	1984 Actual Payments Or Costs	1985 Actual Payments Or Costs	1986 Actual and/or Est. Payments Or Costs	1987 Estimated Payments Or Costs	1988 Estimated Payments Or Costs	1989 Estimated Payments Or Costs	1990 Estimated Payments Or Costs	33% 88-90 Average	Per Diem Rates To Be Requested
NURSING HOME CARE:									
V.A. Participation-									
Veterans Administration	$ [illegible]	$ [illegible].94	$ [illegible] (3)	$12[illegible].04(5)	$123.[illegible] (5)	$126.96 (5)	$129.95(5)		
Community contract	$ 55.[illegible]	$ 59.87	$ 64.[illegible] (3)	$ 69.53(5)	$ [illegible] (5)	$ [illegible] (5)	$ [illegible](5)		
State Home Program	$ [illegible]4.60	$ [illegible]	$ [illegible] (4)	$ 17.05(4)	$ 17.[illegible] (4)	$ [illegible].05 (4)	$ [illegible].05(4)		
State Home Program Costs	$ 63.[illegible]4	$ 67.[illegible]	$ [illegible] (3)	$ 75.63(6)	$ 80.22 (6)	$ 84.66 (6)	$ 89.57 (6)	$25.40 (9)	$25.40 (9)
Percentage of V.A. Participation To State Home Costs	23.[illegible]%	2[illegible].35%	23.6[illegible]% (4)	22.54%(4)	[illegible]	[illegible]% (4)	9.03% (4)		
DOMICILIARY CARE:									
V.A. Participation-									
Veterans Administration	$ 41.8[illegible]	$ 43.62	$ 44.[illegible] (3)	$ 46.25(7)	$ 48.[illegible] (7)	$ 49.85 (7)	$ 51.59(7)		
State Home Program	$ 7.[illegible]0	$ 7.30	$ 7.[illegible] (4)	$ 7.30(4)	$ 7.30 (4)	$ 7.30 (4)	$ 7.30(4)		
State Home Program Costs	$ 37.95	$ 38.24	$ 40.45 (3)	$ 42.91(6)	$ 45.29 (6)	$ 47.92 (6)	$ 50.70(6)	$14.37 (9)	$ 14.37 (9)
Percentage of V.A. Participation To State Home Costs	18.7[illegible]%	9.[illegible]8%	8.[illegible]%(4)	[illegible].25% (4)	6.[illegible]% (4)	5.23% (4)	4.39% (4)		
HOSPITAL CARE:									
V.A. Participation-									
Veterans Administration Intermediate Care Beds	$122.33(2)	$135.22	$14[illegible] (3)	$151.74(8)	$163.27 (8)	$175.68 (8)	$ 89.03(8)		
State Home Program	$ 13.84	$ 15.25	$ 15.25 (4)	$ 15.25(4)	$ 15.25 (4)	$ 15.25 (4)	$ 15.25(4)		
State Home Program Costs	$1[illegible].30	$160.96	$176.[illegible] (3)	$189.53(6)	$200.52 (6)	$2[illegible]2.[illegible]5 (6)	$224.45(6)	$63.64 (9)	$ 63.64 (9)
Percentage of V.A. Participation To State Home Costs	9.94%	9.47%	8.[illegible]%(4)	8.04%(4)	7.6[illegible]% (4)	7.18%(4)	6.79% (4)		

NOTES: (1) Taken from Summary of Medical Programs, Sept. 1985, V.A. Office of Information, Management and Statistics.

(2) Taken from Medical Programs Fiscal Year 1986, Volume II, Office of Budget and Finance Controller, Washington, D.C.

(3) See Schedule I.

(4) Current V.A. per diem rates and [illegible]

(5) See Schedule [illegible].

(6) Used Base Year as 1986 and increased by [illegible]% annually as shown in Schedule [illegible], for SVHC.

(7) Based upon Domiciliary Care average percentage of increase from 1984 through 1986 which equals [illegible]%.

(8) Based upon Intermediate Care average percentage of increase from 1984 through 1986 which equals 7.[illegible]%.

(9) [illegible] the expressed [illegible] of the per diem [illegible] by the V.A. [illegible] to cover 33% of the average daily rate of all homes [illegible] operating.

EXHIBIT D

PROPOSAL TO ANCHOR STATE HOME PER DIEM RATES BASED ON 30% OF THE AVERAGE PER DIEM COST OF NURSING HOME AND DOMICILIARY CARE PROVIDED IN VETERANS ADMINISTRATION FACILITIES

WHICHEVER IS THE LESSER:

30% of the average per diem cost of nursing home and domiciliary care in Veterans Administration Medical Centers from the previous fiscal year not to exceed 50% of the per diem costs of domiciliary or nursing home care in an individual State Veterans Home during the current fiscal year which is currently allowed by law.

EXAMPLE:

Fiscal Year 1986

	Average V.A. Per Diem Cost	30%	State Veterans Home Per Diem Reimbursement for 1987 or 50% of the Cost of Care Whichever is the Lesser
Domiciliary	$ 47.16	$14.14	$14.14 *
Nursing Home Care	118.24	35.47	35.47

*EXPLANATION:

1. If per diem costs in the individual State Veterans Homes are greater than the $28.28 for domiciliary care or $70.94 for nursing home care, the State Veterans Home would receive the 30% rate.

EXHIBIT D
Page 2

2. If the per diem costs for domiciliary and nursing home care were lower than $28.28 for domiciliary care or $70.94 for nursing home care, in an individual State Veterans Home, the Home would receive 50% of their costs for each level of care presently allowed by law.

3. If the per diem cost in an individual State Veterans Home is $28.28 for domiciliary care or $70.94 for nursing home care, the State Veterans Home would receive $14.14 and $35.47 which would be the 30% rate as well as the maximum 50% allowed by present law.

Presently under Title 38, Chapter V - Payments to State Homes, 641(b), Criteria for Payment - "In no case shall payments made with respect to any veteran under this Section exceed 1/2 of the cost of the veteran's care in a State Veterans Home."

This approach takes into consideration a cap as well as compensates State Veterans Homes in those areas of the United States where health care costs are more expensive. It follows a pattern which is demonstrated when one views the per diem reimbursement paid by the Veterans Administration for Community Contract Nursing Care Services throughout the country.

EXHIBIT D
Page 3

Such rates that are indicated in the table for nursing home care could be applicable for the State Homes who provide hospital care. One could always project the per diem rates for State Veterans Homes because you would be utilizing the average cost of care for nursing home and domiciliary in VA Medical Centers of the previous fiscal year.

Whatever percent agreed upon for the formula could be plugged in without difficulty.

It is interesting to note that under existing law, the maximum per diem rate the Veterans Administration may pay for contract nursing home care is 45% of the cost of care in a VA general hospital, or where deemed necessary, 50% of that cost.

5/21/87

EXHIBIT E

PATIENT OBLIGATION DATA

Activity	1986 Actual	1987 Budget	1987 Estimate	1988 Estimate	Increase(+) Decrease(-)
Average obligation/patient day:					
Medical bed sections......	$316.91	$335.34	$345.04	$364.98	$+19.94
Surgical bed sections.....	415.43	428.17	455.50	486.01	+30.51
Psychiatric bed sections..	165.56	173.73	171.29	180.73	+ 9.44
Intermediate bed sections.	136.92	145.13	141.25	142.57	+ 1.32
VA hospitals..........	255.16	267.46	270.56	283.64	+13.08
VA nursing homes..........	118.24	120.04	123.90	134.51	+10.61
VA domiciliaries..........	47.16	46.11	49.78	53.75	+ 3.97
Contract hospitals........	553.48	607.40	652.86	731.20	+78.34
Community nursing homes...	64.13	69.53	68.62	73.29	+ 4.67
State home domiciliaries 1/	7.30	7.30	7.30	7.30	...
State home nursing 1/.....	17.05	17.05	17.05	17.05	...
State home hospitals 1/...	15.25	15.25	15.25	15.25	...
Obligation/patient treated:					
Medical bed sections......	$2,922	$3,160	$3,001	$3,137	$+ 136
Surgical bed sections.....	4,677	4,952	4,893	5,173	+ 280
Psychiatric bed sections..	5,281	5,798	5,060	5,255	+ 195
Intermediate bed sections.	13,543	14,606	13,311	13,281	- 30
VA hospitals..........	3,994	4,304	4,079	4,264	+ 185
VA nursing homes..........	18,897	21,561	20,556	21,780	+1,224
VA domiciliaries..........	7,492	7,865	8,259	8,940	+ 681
Contract hospitals........	5,323	6,668	6,267	7,019	+ 752
Community nursing homes...	6,845	7,640	7,449	7,978	+ 529
State home domiciliaries..	1,510	1,371	1,371	1,373	+ 2
State home nursing........	3,551	3,668	3,668	3,674	+ 6
State home hospitals......	748	671	740	741	+ 1

1/ Reflect statutory per diems.

Veterans Administration, Medical Programs, Fiscal Year 1988
Office of Budget and Finance (Controller), Washington, D.C.

5/21/87

EXHIBIT F

NATIONAL ASSOCIATION OF STATE VETERANS HOMES
PERCENTAGE ANALYSIS
of
PER DIEM INCREASE RECOMMENDATIONS

	FY1985-86 {1}	FY1986-87 {2}	FY1987-88 {2}	FY1988-89 {2}	FY1989-90 {2}
DOMICILIARY CARE:					
STATE HOMES AVERAGE PER DIEM COSTS:	$ 40.46	$ 42.81	$ 45.29	$ 47.92	$ 50.70
S-2, S-216 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE: {3}	$ 7.30	$ 7.30	$ 8.70	$ 8.70	$ 8.70
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	18.04%	17.05%	19.21%	18.16%	17.16%
NURSING CARE:					
STATE HOMES AVERAGE PER DIEM COSTS:	$ 71.48	$ 75.63	$ 80.02	$ 84.66	$ 89.57
S-2, S-216 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE:	$ 17.05	$ 17.05	$ 20.35	$ 20.35	$ 20.35
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	23.85%	22.54%	25.43%	24.04%	22.72%
HOSPITAL CARE:					
STATE HOMES AVERAGE PER DIEM COSTS:	$179.14	$189.53	$200.52	$212.15	$224.45
S-2, S-216 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE:	$ 15.25	$ 15.25	$ 20.35	$ 20.35	$ 20.35
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	8.51%	8.05%	10.15%	9.59%	9.07%
NURSING - HOSPITAL CARE COMBINED: {4}					
STATE HOMES AVERAGE PER DIEM COSTS:	$ 77.92	$ 82.44	$ 87.22	$ 92.28	$ 97.63
S-2, S-216 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE:	N/A	N/A	$ 20.35	$ 20.35	$ 20.35
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	N/A	N/A	23.33%	22.05%	20.84%

5-12-87

5/21/87

NOTES TO THE
NATIONAL ASSOCIATION OF STATE VETERANS HOMES
PERCENTAGE ANALYSIS
of
PER DIEM INCREASE RECOMMENDATIONS

NOTE {1}: Per Diem Costs for the Fiscal Year 1985-86 were extracted from the report; "Veterans Administration Federal Grants Applicable to Domiciliary, Nursing, and Hospital Care Provided by State Homes", Office of Extended Care (182), Department of Medicine and Surgery, Veterans Administration, Washington D.C.

NOTE {2}: Per Diem Costs for all remaining years were projected based on an average annual increase of 5.8% as utilized by the Veterans Administration in it's report; "Adequacy of Per Diem Rates", 38 USC 641CC, June 30, 1986.

NOTE {3}: Per Diem Reimbursements are actual for fiscal years 1985-86 and 1986-87. For fiscal years 1987-88, 1988-89, and 1989-90 they are as recommended in S6 and S216.

NOTE {4}: The Per Diem Costs for Nursing - Hospital Care Combined were calculated based on the information provided in the reports noted in Notes 1 and 2.

JJD:rr:rah

5-12-87

EXHIBIT F
Page 2

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

E. PHILIP RIGGIN, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

ROBERT E. LYNGH, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

VARIOUS HEALTH CARE LEGISLATION

May 21, 1987

STATEMENT OF ROBERT E. LYNCH, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
MAY 21, 1987

Mr. Chairman and Members of the Committee:

We appreciate this opportunity to offer The American Legion's views on the several proposals relating to veterans health care benefits and services that are under consideration during today's hearing.

S. 6 - Section 2 of this measure would amend section 601(6) of the title by authorizing the Veterans Administration to furnish services to help a male or female veteran or a male veteran's spouse achieve pregnancy in cases in which the veteran's service-connected disability impairs procreative ability. According to the introductory statement that accompanied this legislation there are a relatively limited number of veterans who would be eligible for these services and an even smaller number who would avail themselves of them.

Obviously, the vast majority of those individuals who would receive this assistance are Vietnam veterans who, without the application of special procedures to overcome the service-connected impairment of their procreative ability, would not be able to parent natural children. In consideration of these circumstances, we support the intent of this section.

Section 3 would amend section 610(b) of title 38 with respect to eligibility for domiciliary care. As we interpret this section it would merely clarify the language that sets forth the eligibility criteria for domiciliary admissions and we have no objection to such a clarification.

Section 4 of S. 6 would amend 612A of the title by expanding the eligibility criteria for the provision of readjustment counseling, and provide for a one-year extension of the date by which VA's readjustment counseling program (Vet Centers) is to begin transition from a storefront type of operation to VA's general medical facilities.

Under this section, the report that the Administrator is to submit to Congress regarding the effectiveness of the program would contain findings as to whether or not veterans of World War II and Korea could benefit from services provided by this program.

This section would also make eligible for readjustment counseling services those current members of the Armed Forces, who also served on active duty during the Vietnam war. In addition, it would provide eligibility for these services to individuals who served in the Armed Forces after Vietnam, and who were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat during a period of war.

The American Legion views favorably the provision of readjustment counseling to those persons serving on active duty who also served in Vietnam. As far as we have been able to determine, there are few if any readjustment counseling services available in military medical facilities to address problems related to post-traumatic stress disorder, and other readjustment issues. Perhaps more importantly, as we have mentioned in the past, if such counseling programs were available, through the military, it is unlikely that many individuals on active duty would seek assistance from them. Most veterans of Vietnam who have continued their military service are career-oriented senior enlisted personnel and officers who would not jeopardize their future advancement by submitting themselves for treatment of any condition that could be construed as "psychiatric" in their service medical records.

Likewise, we would not object to the extension of eligibility for readjustment counseling to those individuals in service during periods of time and in specific locations in which U.S. Armed Forces were engaged in combat. There is no doubt that the Marines in Beirut, and many of the Army, Navy, Air Force and Marine Corps personnel involved in the invasion of Granada were faced with life-threatening incidents - the precursor of

PTSD. Unlike the situation that existed when veterans were returning from Vietnam, much more is now known about the causes, effects, diagnosis and treatment of PTSD. We would hope that the latest group of American troops involved in combat were provided a period of desensitization or decompression, much like that provided the American hostages upon their release from Iran. A program of this nature should alleviate future problems for many of these military personnel.

Delegates to The American Legion's 1986 National Convention adopted Resolution No. 548, which reiterates The American Legion policy on transition of the Vet Center Program. The resolve clause states that The American Legion support legislation to amend title 38, USC, "by eliminating the date (September 30, 1988) by which the transition of the readjustment counseling program from the Vet Centers into VA medical care facilities is to be accomplished..." The final resolve clause reads basically that assimilating the program must be "made on a case-by-case basis, as the utilization of services diminishes."

Section 5 would require the VA to conduct, from January 1, 1988, through December 31, 1991, a 4-year pilot program at not less than 5, nor more than 10 demonstration project sites to evaluate noninstitutional alternatives to institutional care. Through the pilot program, the VA would provide certain veterans with medical, rehabilitative and other health services. In addition, it would provide other health-related services through contract with non-VA entities. Participation in the pilot program would be limited to veterans eligible for and otherwise in need of VA hospital, nursing home or domiciliary care. Priority would be accorded veterans with service-connected disabilities, to veterans age 65 or older, to veterans who are permanently and totally disabled, and those veterans who are suffering from Alzheimer's disease or another form of dementia.

The health and health-related services would be provided through settings such as the veteran's home or a board-and-care home. The goal is to be able to avoid institutional care for the participants in the program.

Each veteran involved in this program would have a VA case manager responsible for the veteran's access to the appropriate combination of needed services such as medical care and health related services.

Mr. Chairman, The American Legion has over the past several years consistently supported the theory of maintaining the veteran patient in the community as much as, and for as long as possible. In our analysis of the VA report entitled "Caring For The Older Veteran" it is pointed out that in looking to the future from the Legion's standpoint, we will have to realize the fact that many more veterans will be receiving health care in community settings under the Veterans Administration's guidance. Cooperative efforts with community programs are already underway to a limited degree. It is important that these efforts be expanded, and that liaisons with community resources that share VA's interest in the aging are maintained. In addition, our analysis of the report emphasizes that alternative care programs featuring noninstitutional care settings must be aggressively pursued to help contain costs.

On a number of occasions during hearings before this Committee, we have stated that it is our intent to encourage both Congress and VA to foster the development and implementation of all of the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients.

Section 6 of this proposal would amend section 621 of title 38, to eliminate the authority of the Administrator of Veterans Affairs to prescribe limitations on the furnishing of hospital, nursing home and domiciliary care by VA as he deems proper and necessary. We understand that this authority dates from the Economy Act of 1933, and has rarely, if ever, been used.

The American Legion has no objection to repealing this authority.

Section 7 of this measure would amend section 641(a) of title 38 by increasing the per diem rates for payments by the Veterans Administration to State Homes for care provided to veterans.

The per diem rate for domiciliary care would be increased from $7.30 to $8.70; the rate for nursing home care would increase from $17.05 to $20.35 and the rate payable for hospital care would be increased from $15.25 to $20.35. It is our understanding that if such increases were enacted, however, supporting funds would possibly have to come from existing medical care funds. The American Legion does not feel that it is appropriate to penalize other programs in order to provide these much needed increases in per diem rates.

The American Legion does, however, strongly support this proposed increase in per diem rates. We are mandated through Resolution No. 195, adopted by the Delegates to our 1986 National Convention, to support an annual review and revision of the rates of reimbursement by the Veterans Administration for the care provided veterans in State Homes.

We are very much aware that 38 USC 641(c) currently requires the Administrator to submit a report every three years to the Committees on Veterans Affairs on the adequacy of the per diem rates payable to each State for domiciliary, nursing home and hospital care for each veteran receiving such care in a State Home. The first report was to have been submitted not later than June 30, 1986. The American Legion believes that the fair sharing of the cost of providing extended care for elderly and disabled veterans will encourage States to meet the needs of the aging veteran population, and we urge that the per diem rates be increased as set forth in this measure.

The American Legion has no objections to the proposal outlined in section 8 which provides for a revision of the table of organization for the Office of the VA's Chief Medical Director to establish a second Associate Deputy CMD position and to authorize appointment of certain health care professionals other than physicians to various positions in that office.

Section 9 of S. 6 would permanently prohibit the Administrator from taking any action to declare as excess, transfer, or otherwise relinquish any VA interest in any portion of certain lands at two VA medical centers in California. Specifically, this section is in reference to the 46 acres at Sepulveda and 109 acres at West Los Angeles.

Mr. Chairman, The American Legion will continue to oppose the transfer of any portion of the land herein discussed to anybody, for any purpose other than to continue to provide care for veterans. The complex of land described herein encompasses a wide variety of activities for the care of perhaps the largest single concentration of veterans to be found in the nation. There is no possibility that the scale of veterans activities now being carried on at West Los Angeles will be in any way scaled down for the foreseeable future. Therefore, Mr. Chairman, The American Legion fully supports this proposal to enact a permanent solution to this situation.

The final section of S. 6 identifies the need to prepare for the impact of the aging of the U.S. population and the importance of VA playing a leadership role in that regard. This provision addresses the need to further strengthen endeavors with affiliated institutions in regard to their training and research efforts in the area of aging. Through this provision the Administrator would be required to submit a report setting forth detailed information with regard to past, present and planned efforts at affiliated institutions. The vast amount of information contained in this report, including numbers, costs, student identification, successes and failures of affiliations, locations and plans for future geriatric programs, when provided to the Committees, will be used to determine the extent to which VA has had an impact on affiliated institutions in regard to caring for the aging veteran.

The American Legion supports this proposal. This organization has always considered VA's training and research efforts in the area of aging to be of vital importance. Delegates to our 1986 National Convention adopted Resolution No. 126 (NC) which urges VA to plan and develop a comprehensive health care program and related services for the aging veteran. Information obtained through the report which would be required if this proposal was enacted, would serve the VA and others extremely well in determining future direction of such a program.

The VA has been somewhat negligent in preparing any solid plans for meeting the needs of the increasing number of aging veterans. This is the most serious challenge ever presented to the VA system. The overall welfare of elderly veterans in the near and distant future relies completely on actions that must be accomplished now. The needs of the aging veterans have been identified over and over again. What is now needed, and imminently, is a comprehensive plan detailing how VA will meet this tremendous challenge.

S. 216 proposes to amend title 38, United States Code, to increase the per diem rates paid to States for providing care to veterans in State Homes. The position of The American Legion on this proposal is set forth in our comments on section 7 of S. 6. As stated, we are very much in favor of these proposed increases, and therefore, support the intent of S. 216.

S. 631 proposes to improve the procedures for the procurement of medical and pharmaceutical supplies by the Veterans Administration. The bill states the Administrator shall, within three years after enactment, develop and fully implement an agency-wide plan for the standardization of all medical and pharmaceutical supplies procured by VA. In addition, this plan must provide for the procurement of generic medical and pharmaceutical supplies.

The American Legion does not see any problems with the four substantive provisions included within this proposed bill, and therefore, we do not object to this proposal.

Mr. Chairman, the next bill under consideration is S. 713, cited as the "Veterans Administration Registered Nurse Variable Incentive Bonus Act of 1987."

This proposed legislation would authorize VA to pay, in addition to all other pay and allowances, up to a $20,000 bonus to Registered Nurses who agree to serve on a full-time basis at a specific geographic location, or in a professional specialty, for three or more years.

There are problems in recruiting and retaining nurses on a widespread basis across the nation in both the public and private sectors. The problems, of course, are more complex in VA than in community hospitals, because even when special pay rates are implemented at a VA medical center, they are usually inadequate in comparison with what is being offered in the private sector.

The American Legion supports this proposal that will hopefully address recruitment problems associated with nurses. However, as this Committee well knows, similar recruitment and retention problems exist nationwide for pharmacists, physical therapists, and occupational therapists. In our view, a more appropriate approach would be to address all of these shortcomings at one time. It is obvious that some changes are going to have to be made, including improved benefits and pay for these employees, as well.

S. 914 is a bill designed primarily to clarify existing legal authority. One proposal would amend the statutory definition of the term "nursing home care" to include both skilled and intermediate levels of care. The American Legion does not object to this proposal based on the fact that VA has always provided these levels of care in its nursing homes.

This proposal would also clarify VA's authority to provide veteran patients with therapeutic recreational activities outside the confines of a VA facility. Enactment of this bill would establish specific legal authority for such activities, and The American Legion has no objection to this proposal.

Included within S. 914, is a proposal that would make persons disabled by VA treatment, examination, or vocational rehabilitation eligible for outpatient care for the disability for which compensation is being awarded under section 351, title 38, USC. Such persons are currently eligible for VA hospital and nursing home care as if service-connected, but are eligible for limited outpatient care, primarily to obviate the need for hospitalization or to complete hospital care.

The American Legion supports this proposal to provide eligibility to persons disabled by VA treatment, examination, or vocational rehabilitation for outpatient care to the same degree as service-connected veterans.

S. 915 is a proposal to amend title 38, United States Code, to authorize the Chief Medical Director to waive State licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care, and for licensed or vocational nurses, and physical therapists to be employed in a foreign country.

The Chief Medical Director currently has the authority to make such waivers in cases of physicians, dentists, psychologists, podiatrists, and optometrists, and we have no objection to the inclusion of these other personnel for the purposes set forth in 38 USC 4114(d). The American Legion would stress however, that strict controls must be maintained on such individuals to ensure that their limited appointment is not forgotten, and that they do not eventually assume patient responsibilities.

S. 894 would amend section 624(b) of title 38 so as to authorize the Administrator to furnish necessary hospital care and medical services to any otherwise eligible veteran for any service-connected disability if the veteran is residing abroad, whether or not the veteran is a U.S. citizen.

The American Legion is mandated to support this bill as a result of Resolution No. 547 approved by the Delegates to the 1986 National Convention. The reason for this support is that many foreign nationals have enlisted in the U.S. Armed Forces during armed conflicts against an enemy of the United States. Many of these individuals were injured in the performance of duty, often under hostile fire. Heretofore, they have not been eligible for fee-basis treatment of these service-connected disabilities. The enactment of this legislation would be of significant importance to those Canadian citizens who enlisted in the U.S. Armed Forces during the Vietnam War. They, and the other foreign nationals who have gallantly served this nation's Armed Forces are certainly deserving of this eligibility for treatment of their service-connected disabilities.

S. 105 is a bill to amend Chapter 73 of the title to authorize the Administrator to pay incentive special pay to certain psychologists who meet specific criteria, and who agree to complete a specified period of service in the Department of Medicine and Surgery.

The American Legion has no objection with this proposal, as similar incentives are currently available to other health care professionals.

S. 939 would amend section 603(a) of the title to provide the Veterans Administration with the authority to pay for emergency hospital care for veterans who have been placed in community nursing homes at VA expense.

The American Legion is supportive of this provision.

The second proposal contained in this bill would amend section 620 by authorizing the Veterans Administration a maximum per diem rate for contract nursing care of 50 percent of the cost of care in a community general hospital in Alaska and Hawaii, as opposed to the current limitation of 45 to 50 percent of the cost of care in a VA general hospital. This should provide VA with greater ability to obtain needed care for veterans in those two States, and we would support it.

The third provision set forth in S. 939 would amend section 624(b) of the title to provide service-connected veterans who are foreign nationals residing abroad with eligibility for VA health care for their service-incurred disabilities. As the letter of transmittal states, this change would primarily benefit a group of Canadian citizens who were disabled while serving with U.S. forces in Vietnam. As previously stated, The American Legion urges the enactment of this proposal.

This measure would also clarify VA's authority to provide medical services to veterans participating in a vocational rehabilitation program outside the U.S., and we support that intent.

S. 1062 involves amendments relating to the Chief Medical Director's authority with respect to probationary periods and disciplinary actions on certain title 38 health care employees. The American Legion has no position on this legislation, basically because it entirely involves internal personnel matters relating to the VA.

S. 1063 would make several amendments in the administering of tort claims and hospital cost collections. The measure would clarify the statute of limitations applicable to suits brought by the U.S. to recover its costs of health care pursuant to 38 U.S.C. 629. It would also expand the immunity from personal liability for VA health care personnel to that afforded health care personnel of other agencies. The measure would, in addition, remove a statutory limitation on the authority of the Administrator to settle administrative tort claims under the Federal Tort Claims Act.

The American Legion has no objection to the provisions of this bill.

S. 1065 would amend section 4107 of title 38 to provide on-call pay to certain VA health care personnel employed under title 5, or title 38, section 4104(3). The on-call pay would be available for the above-listed personnel who are officially scheduled to be on-call outside his or her regular hours or on an official holiday. It would be paid at a rate equal to 10 per centum of the hourly overtime rate for services in excess of regularly scheduled duty for each hour of on-call duty. This would alleviate the necessity of having to place the employees in standby duty status.

The American Legion has no objection to this proposal.

S. 1089 would provide two amendments to the State veteran home program as revised under PL 99-576.

On July 1, 1987, the current State home grant award procedures that require grants to be awarded in order of the date the application is received, will be replaced with procedures requiring prioritization of grant projects. Although VA has a large number of applications on file, the new law did not include a "grandfather" clause, for applications pending for some time, or interim procedures for approving such applications. The law does call for VA to award grants in the order of their priority, as established on a July 1 priority list, during the fiscal year beginning on October 1 of the calendar year in which the list was made. Therefore, there is a period from July 1 to October 1, 1987 wherein there is no authority for providing grants. This bill would establish an interim mechanism that would permit VA to award a grant between June 30 and October 1, 1987, if it had previously notified the State of the availability of funds for the grant. The application would have to meet all requirements for approval.

The second amendment would permit the Administrator to approve and obligate funds for a State home grant for a project which is high enough on a priority list to be notified of the availability of Federal funds even though the State has not met all the requirements for a grant. This would reportedly reduce the unobligated balance of State home grant funds that would be carried into the next fiscal year. In addition, it is felt it would give States sufficient time to meet all the requirements for grants if their proposed projects are high enough on the priority list to be notified that Federal funds are available for them.

The American Legion views this measure favorably, as it would alleviate some inequities that currently exist, although they were probably not forseen when section 224 of PL 99-576 was enacted.

S. 1125 would authorize modification of the structure of the Office of the Chief Medical Director, and provide authority for other administrative procedures.

These are all administrative changes to which we have no objection.

S. 1136 would amend section 4110 of title 38 to limit the function of disciplinary boards appointed by the Chief Medical Director to determining changes in the more severe personnel actions which require a higher degree of due process protection, in the case of certain non-probationary full-time health care professionals. The bill would also allow delegation of certain authority to officials below the level of Chief Medical Director.

Here again, these are administrative issues proposed by the Administration and we do not object to them.

S. 279 calls for an amendment to section 612A(g) of title 38 to postpone the transition of the Vet Center program from October 1, 1989 to October 1, 1990. It also extends by one year each of the reports that must be submitted relative to the transition; and the due date of the report on the study of post-traumatic stress disorder among Vietnam veterans.

Mr. Chairman, The American Legion supports the intent of this measure. As previously stated, the Delegates to the 1986 National Convention approved Resolution No. 548, which reiterates the organization's policy on the transition of the Vet Center program. It places us in a position to support legislation to eliminate the date by which the transition of the Readjustment Counseling program from the Vet Centers into VA medical care facilities is to be accomplished, and that the Legion support a continuation of the Vet Center program, contingent on a plan wherein decisions on assimilating the Readjustment Counseling program into the VA medical centers will be made on a case-by-case basis, as the utilization of services diminishes. While S. 279 does not entirely satisfy Resolution No. 548, it is an improvement.

Mr. Chairman, the last measure that we shall address is S. 1195, a bill that contains a number of provisions relating to VA health care personnel.

Section 2 of the bill would amend section 4104 of the title so as to provide VA with flexibility in appointment and pay matters relating to pharmacists and occupational therapists.

The American Legion supports this proposal, and trusts that it will be of assistance in the current problems relating to the recruitment and retention of these two categories of health care personnel.

This section would also amend section 4107(f) to authorize additional pay for pharmacists and occupational therapists on the same basis as nurses.

We support this proposal for the same reasons listed above.

Section 3 would amend section 4107(e) to provide for nurses who work on Saturday the same premium pay now applicable to Sunday work.

The American Legion, cognizant of the nationwide nurse shortage and the problems VA is having in recruiting and retaining nurses, strongly supports this proposal.

Section 4 provides that nurses be included in the Special Medical Advisory Group and other advisory bodies.

We support this proposal as the input of nurses is important in overall medical planning.

Section 5 would repeal subchapter IV of chapter 73 which relates to the Veterans Administration Health Professional Scholarship Program.

The section would also establish a new chapter 76, entitled "Veterans'

Administration Health Professional Scholarship Program" under which are set forth a scholarship program and a tuition reimbursement program, the purposes of which are to assist in the provision of an adequate supply of trained health care professionals in the VA.

Some of the major changes contained in the new program include lengthening the period of obligated service under the scholarship program from one year for every year of support to two years for every year of support, and provide priority for nurses seeking a fourth year of baccalaureate training; establishing a tuition reimbursement program for full-time nursing personnel, and other health care personnel when needed, for academic courses leading toward completion of a degree program; and adding physical therapists to those eligible for the health professional scholarship program.

Upon preliminary review, we find that the proposed program contains improvements over the current program, such as those listed above, which we feel would certainly help in the recruitment and retention of health care professionals. However, as with the program that is now in effect, the benefits of the proposal will only be worthwhile when funds are available, and, as you know Mr. Chairman, appropriations for the current scholarship program have been sporadic since its inception.

Mr. Chairman, that concludes our statement.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
May 21, 1987

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I deeply appreciate this opportunity to appear here today to present our views on legislation relating to the Veterans Administration's health care system.

Mr. Chairman, your letter of invitation to testify solicited our views relating to numerous pieces of legislation requiring this Committee's attention and action.

Our testimony has been requested regarding the following bills: S. 6, "The Veterans Health Care Improvement Act of 1987;" S. 105; S. 216; S.631, the "Veterans Administration Procurement Improvement Act of 1987;" S. 713, "The Veterans Administration Registered Nurse Viable Incentive Bonus Act of 1987;" S. 894; S. 915; S. 939, "The Veterans Health Care Benefits Administration Act of 1987;" S. 1062; S. 1063, "The Veterans Administration Tort Claims and Hospital Cost Collections Amendments of 1987; S. 1065; S. 1089; S. 1125; S. 1136; and the "Veterans Administration Health-Care Personnel Act of 1987."

S. 6

Section 2 of the bill proposes, through appropriate amendment to Clause (A) of Section 601(6), Title 38, United States Code, to include in the definition of medical services "...services to achieve pregnancy in a veteran or a veteran's spouse where such services are necessary to overcome a service-connected disability impairing the veterans' procreative ability...."

While the DAV has no official position to the perceived intent of this measure, we feel explanatory report language is required to express the limitations of this bill.

Our interpretation is that services would be provided to "...achieve pregnancy..." (emphasis added). Therefore, we do not envision the VA to be required to provide obstetric services, prenatal or postnatal care in conjunction with any successfully achieved pregnancy. We would also raise the issue of the Agency's potential liability relating to possible complications and/or permanent disability to the mother or possible birth defects affecting the child.

Mr. Chairman, the DAV supports Section 3 of the bill which proposes to amend Subsection (b) of Section 610, Title 38, United States Code, to clarify and simplify the eligibility criteria for receiving domiciliary care.

Section 4(a) of the measure would amend Section 612A, Title 38, United States Code, regarding eligibility for readjustment counseling and related mental health services to certain veterans and individuals who:

* are still on active duty and served on active duty during the Vietnam Era; or

* are veterans or are serving on active duty and served on active duty after May 7, 1975, in an area during a period in which hostilities occurred in such area.

Mr. Chairman, we have no objection to expanding eligibility for readjustment counseling to those veterans who served on active duty after May 7, 1975, and were subjected to dangers from hostile or armed conflict, comparable to the dangers experienced by military personnel in battle with the enemy during a period of war.

However, we do not favor extending these types of counseling services to active duty personnel. If a need exists for active duty personnel to receive readjustment counseling services, it is certainly feasible and within the realm and responsibility of the Department of Defense to provide these types of services by utilizing their existing resources or by entering into a sharing agreement with the Veterans Administration.

Mr. Chairman, Section 4(b) of S. 6 would, in essence, provide for the delay, by one year, of the date on which the two year "transition period" of the Vietnam Veterans Readjustment Counseling Program is to begin -- from a program providing such services primarily through centers located in facilities situated apart from the health care facilities operated by the VA to a program providing readjustment services primarily through VA operated health care facilities -- from October 1, 1987 to October 1, 1988.

Additionally, this measure would provide for a one year delay in the due dates of the three separate reports required by Section 612A(g), Title 38, United States Code.

These consist of:

1. A report, due by April 1, 1987, which would state the Administrator's evaluation of the VA's effectiveness in meeting the readjustment needs of Vietnam veterans and his opinion as to the feasibility of moving forward with the transition effort;

2. A report, due by July 1, 1987, setting forth a plan and timetable for accomplishing the transition; and

3. A report, due by February 1, 1989, setting forth the VA's experience during the initial period of the transition process.

Mr. Chairman, the intent of this measure is clear when one considers the considerable difficulties the VA has encountered in attempting to "get off the ground" a comprehensive study relating to post-traumatic stress disorder (PTSD). This mandated study was designed to identify the prevalence and incidence among Vietnam veterans of PTSD -- as well as other post-war psychological problems in readjusting from their military service.

It is unfortunate and very discouraging that the VA and Research Triangle Institute, Incorporated -- contracted to conduct the study -- have permitted the timetable to complete the study to be severely delayed. Without belaboring the issue, it is our understanding that the final report of the study will not be completed until December, 1988, a full two years behind the original due date.

Mr. Chairman, the DAV has continually expressed our commitment toward assisting Vietnam veterans suffering psychological problems associated with their military service. As you know, the DAV provided funding as early as 1976 for "The Forgotten Warrior Project" a study which lead, in October, 1978, to the DAV initiating our Vietnam Veterans Outreach Program. We feel it was, in large part, due to our efforts that the VA created their current network of Vet Centers.

We believe this program has been and will continue to be utilized by veterans of the Vietnam Conflict. However, we wish to reiterate our strong support for the concept that the VA must move forward to integrate these services into the mainstream of traditional and existing VA health care facilities -- VA medical centers.

Mr. Chairman, in view of the fact that the comprehensive PTSD study is required by law to be used in preparing the reports relative to the transition process, and because it is clear that the Administrator will not have the benefit of the study results for the preparation of the report due by April 1, 1987, and, if a consensus is reached that the results of the PTSD study are vital and necessary to formulate the various transition reports, we would not object to the enactment of this legislation.

We do, however, wish to state our disappointment regarding the delays that have occurred because of the apparent flaws in the study's design. Also, we would strongly urge the VA to do everything possible to move swiftly to insure the completion of this vital study. To do less would not be in the best interests of Vietnam veterans.

Section 5 would mandate the Administrator, to conduct a pilot program to furnish medical, rehabilitative and health related services in a non-institutional setting that would obviate the need for hospital or nursing home care.

Initially, Mr. Chairman, I want to state that the DAV supports this concept. We have long advocated that providing necessary medical and certain non-medical services to veterans to avoid institutionalization is a desirable approach, both from a cost effectiveness standpoint and, more importantly, for the overall well-being of the veteran.

Mr. Chairman, to enable these provisions to succeed in their intent, we feel it desirable to define, in part, what is envisioned by the term "health related services." This term should, in our view, include, but not be limited to:

Domestic
Bathing
Feeding
Grooming
Changing patient's clothes
Transporting patients
Oral hygiene
Dressing
Diet Management

Homemaker
Housecleaning
Food Preparation
Marketing
Washing clothes

Custodial
Assistance with daily needs
Turning patients
Catheter irrigation
Massage
Ambulation
Sitter services
Changing colostomy bags
Changing simple dressings
Changing external catheters
Medicine Administration
Assistance with prosthetic devices
Position adjustment/transfers

Mr. Chairman, because we believe that flexibility in providing these types of non-medical support services is essential to obviate the need for institutionalization, we suggest, if this measure is favorably reported, that such services be defined as cited above.

Additionally, Mr. Chairman, we are pleased to note that this measure stipulates that the Administrator shall give priority for participation in the program to veterans with service-connected disabilities, as well as other veterans who, by virtue of their disabilities, would be most in need of such services.

Section 6 of the bill would amend Section 621, Title 38, United States Code, by, as we understand it, substantially revising the Administrator's authority to issue rules and regulations relating to the provision of VA medical care.

The VA's Office of General Counsel drafted a white paper in conjunction with last year's Congressional actions regarding the Omnibus Budget Reconciliation Act of 1985 wherein Section 621 was the subject of some discussion.

Mr. Chairman, it was concluded by the General Counsel that Section 621, as currently constructed and codified, grants the Administrator broad authority and significant discretion to determine what medical care should be provided or not provided to otherwise eligible veterans. In fact, it was readily acknowledged that Section 621 would allow the Administrator to deny medical care to veterans who otherwise required such care.

This provision would, in our view, mandate the Administrator to prescribe all rules and regulations governing the furnishing of VA hospital, nursing home and domiciliary care, as well as medical services, under laws administrated by the Veterans Administration and which are consistent with such laws.

As we feel this measure would require the Administrator to comply with the intent of Congress, thereby limiting his discretionary authority, we have no objection to enactment of this provision.

Section 7 would provide for increased per diem rates, payable by the Veterans Administration, to State homes for the provision of domiciliary, nursing home and hospital care to disabled veterans.

Mr. Chairman, the DAV has long advocated support for the State Home Program and the benefits presented to the federal government, the states and disabled veterans. Therefore, we fully support adequate increases in the per diem payments as they represent, in our view, a continual commitment to provide cost effective health care services to disabled veterans.

Mr. Chairman, Section 8 would amend Section 4103 of Title 38, United States Code, relating to the organization and composition of the Office of the Chief Medical Director (CMD) to allow for the establishment of a new position -- a second

Associate Deputy Chief Medical Director (ADCMD) and provide flexibility in other appointments within that office.

Generally speaking, the DAV has no objection to any action that would permit the CMD greater flexibility in the day-to-day operations of the Department of Medicine and Surgery. Conversely, so long as direct patient care is not jeopardized, we could support this measure.

However, Mr. Chairman, we have rather serious concerns regarding that portion of Section 8(a)(3)(C) which would, as we understand it, remove the requirement that the position of Assistant Chief Medical Director (ACMD) for Geriatrics be a qualified physician trained in, or having suitable extensive experience, in geriatrics.

As we are all only too well aware, one of the most challenging issues facing the VA today is how the Agency will respond to the future health care needs of the ever-increasing older veteran population.

(I might add at this juncture, Mr. Chairman, that Section 10 of S. 6 very appropriately and timely recognizes this question.)

Mr. Chairman, the VA is certainly not alone in searching for ways and methods to meet the health care needs of older Americans. On the contrary, joint cooperative efforts must be explored and launched with many other federal, as well as community, agencies. To this end, consideration must be accorded to a wide range and variety of other medical disciplines. Therefore, it is our view that in order to maximize the Agency's efforts in this area, a prerequisite must be that the responsible ACMD be a qualified physician.

We urge amending the pertinent part of Section 8 to retain the requirement that the ACMD for Geriatrics be a qualified physician.

The DAV supports Section 9, which would prohibit the Administrator from declaring, as excess, certain lands and improvements at VA Medical Centers, West Los Angeles, California; and Sepulveda, California.

Finally, we have no objection to Section 10, which would require the VA to submit a report to the Committees on Veterans Affairs regarding VA activities, and the success of those activities, designed to promote increased efforts by affiliated medical schools and other health-professional training schools in training health care professionals to care for older patients and in research into the aging process and diseases associated with aging.

S. 105

This measure would create a new section to Subchapter 1 of Chapter 73 of Title 38, USC, mandating the Administrator to pay incentive special pay to any psychologist who:

* executes an agreement with the Administrator to complete a specified period of service in the Department of Medicine and Surgery; and

* is awarded a diploma as a Diplomate in Clinical Psychology or as a Diplomate in Counseling Psychology by the American Board of Professional Psychology; or

* obtains an additional advanced academic degree in public health, which the Administrator determines is in the best interest of the Veterans Administration.

Mr. Chairman, the authority to provide incentive special pay exists due to the recognition that it is frequently, if not always, necessary in order to recruit and retain qualified physicians and dentists to work in the VA health care system.

If there is a true shortage of qualified psychologists in the VA system -- which we have no firm data to suggest -- and, if incentive special pay is a necessary tool to attract and retain qualified psychologists, then the DAV would have no difficulty in lending our full support to this measure.

However, if the enactment of this measure has only the net effect of providing such pay to already employed psychologists who are adequately compensated in relation to their counterparts in the private sector, then we find no compelling reason to support S. 105.

S. 216

Introduced by a distinguished member of the Committee, Senator Mitchell, S. 216 is identical to Section 7 of S. 6. As previously indicated, we are pleased to support this measure.

S. 631

Introduced by Senator Murkowski, this measure would mandate the Administrator to develop and implement an Agency-wide plan for the standardization of all medical and pharmaceutical supplies procured by the VA.

Additionally, a new Subsection -- 5025 -- would be added to Subchapter II of Chapter 81, Title 38, USC, providing that all medical and pharmaceutical supplies would be procured only under national contracts except that a VA medical center may procure such supplies under a local contract only if an emergency need exists or the item or supply is not available under a national contract.

Mr. Chairman, our review of the Coopers and Lybrand Study of the VA procurement process indicates rather substantial savings may be achieved by the implementation of a number of diverse recommendations. The implementation of a system-wide standardization program alone has potential first year savings of $3.6 million.

If, in fact, legislation is required that would permit the VA to move in the direction of improving the procurement process, then the DAV is supportive of the enactment of this measure. However, if administrative initiatives and actions only are required to effect improved efficiency and remedy existing problems, we would then urge the VA to move swiftly in implementing such procedures.

S. 713

Introduced by the distinguished Ranking Minority Member of this Committee, Senator Murkowski, this measure is intended to assist the VA in the hiring of registered nurses by permitting the Administrator to pay a bonus, not to exceed $20,000, to a registered nurse accepting employment with the Agency. Such a bonus would be paid to any registered nurse who agrees, via execution of a written agreement, to:

* be employed on a full time basis in the Department of Medicine and Surgery for a specific period of not less than three years; and

* to serve during that period at a specific geographic location or in a professional specialty for which it has been determined a significant recruitment and retention problem exists.

Mr. Chairman, the DAV applauds and is supportive of the perceived intent of this measure -- to attempt to alleviate a critical shortage of skilled nursing professionals throughout the VA health care system. While the issue of comparable pay for VA registered nurses to their counterparts in the private sector is a major issue which must be addressed, we believe that additional actions must be achieved to remedy the long term situation.

In this respect, I would like to now reference your draft legislation, the "Veterans Administration Health-Care Personnel Act of 1987," and lend our general support to enactment of that measure.

Mr. Chairman, it has been the long held belief of the DAV that the VA's Department of Medicine and Surgery does a commendable job of providing health care services to this nation's disabled veterans.

As vigorously as we hold to this belief and advocate the continuance of the system we, nevertheless, continue to be deeply concerned with the Agency's ability to provide a sufficient number and mix of health care professionals to carry out the VA's mandated mission of providing quality and timely health care services.

Over the years, Mr. Chairman, much anecdotal information has been presented that points to rather dramatic problems within the Agency concerning their ability to recruit and retain a sufficient number of qualified health care professionals necessary to maintain the viability of the system.

The VA operates a highly diversified medical care system which employs more health care professionals than any other single organization in the nation. While some Agency-wide employment data on health care occupations is routinely maintained, comprehensive information concerning local staffing situations is not.

Recognizing this situation the VA conducted a survey of health occupational staff which was completed during January 1987.

The initial phase of this survey presented results for registered nurses, licensed practical nurses, nursing assistants, occupational therapists, physical therapists and pharmacists. The second and final report dealing with the remaining health care occupations has been completed and is scheduled for release within the very near future.

Mr. Chairman, this staffing survey revealed that the overall recruitment and retention situation for registered nurses, licensed practical nurses, occupational therapists, physical therapists and pharmacists was favorable for only about 47% of the VA's medical facilities.

The survey further revealed that 23% of the VA's facilities were experiencing moderate difficulty in recruitment and retention; 21.5% were experiencing serious difficulty; and 9% were experiencing severe difficulties in recruiting and retaining professionals within these occupations.

There were Agency-wide net losses for occupational therapists, physical therapists and pharmacists and a very large net loss for nursing assistants. There were small net gains for licensed practical nurses (3%) and registered nurses (.7%).

Mr. Chairman, the survey findings and results are, in our opinion, comprehensive and forthright regarding the VA's recruitment and retention difficulties.

Following our review of the survey we have noted certain commonalities with reference to all of the occupations reviewed.

It becomes clear that the major problem areas of the Agency's ability to retain these health care professionals are concentrated in the following areas;

- salary differentials;
- work load (patient to staff ratios);
- educational opportunities;
- family reasons; and
- necessity to relocate.

Mr. Chairman, in our view the major barriers identified in the VA's ability to retain qualified health care personnel can be resolved via various administrative and legislative remedies.

Specifically, we would recommend that the Agency intensify it's efforts to:

- encourage and expeditiously act on requests for special salary rates for critical health care personnel;
- establish and maintain a sufficient number of health care personnel -- adequate patient to staff ratios in the nursing service -- as opposed to any decision to maintain less than the full time equivalent employees authorized and funded by Congress; and
- establish and implement a viable mechanism to assist employees who are required, for various reasons, to relocate to other geographical areas.

Additionally, we would suggest that the Committee consider legislative action that would assist the VA in alleviating the identified disadvantages in both recruitment and retention by supporting action that would:

- provide tuition reimbursement for those pursuing degree programs;
- clarify the authority to provide a program of child care facilities;
- expand the authority for utilization of the Health Scholarship Program;
- provide employment opportunities under the authority of Title 38, United States Code, where appropriate; and

* provide pay differentials -- "premium pay" -- for working Saturdays.

Mr. Chairman, it is obvious that the VA, via the results of their own survey, is experiencing rather significant problems concerning the recruitment and retention of various health care personnel crucial to the provision of direct health care services to disabled veterans.

In recent months it has become painfully evident that these problems will become progressively worse, especially concerning registered nurses.

It is evident that the country is entering an era which will witness a crucial shortage of nurses entering and remaining in the work force. The reasons for this situation are many and varied. Simply stated, the VA's ability to employ qualified nurses is dependent, in large part, upon the availability of nurses in the private sector.

With fewer enrollees in nursing schools and the pool of qualified graduates continually declining, as well as competition for these qualified individuals being fierce, the VA's ability to recruit and retain nurses is being severely compromised. This situation will remain and may in fact worsen if current VA employment practices are allowed to continue unchanged.

Undoubtedly, comparable pay to the private sector is a major factor in attempting to remedy this situation. However, increased salaries may prove to be simply a short term solution.

In our view, actions must be initiated, as previously mentioned, that would allow the VA to at least keep pace with the private sector health care industry in the benefits and incentives offered to nurses that would make employment with the VA an attractive employment alternative.

It is our opinion that action is required immediately to provide a long term solution to the existing dis-incentives to employment in the VA's health care system. We would therefore encourage the Agency and this Committee to carefully consider the recommendations made herein.

S. 894

This measure, introduced by Senator Murkowski, would remedy what we view as an inequitable situation regarding the Administrator's authority to furnish VA hospital care and medical services to non-United States citizens who are service-connected disabled veterans but who incurred such disability in service with the United States Armed Forces and who are residing outside of the United States.

S. 894 would amend Section 624(b), Title 38, United States Code, by effectively removing the restrictive requirement of United States citizenship in order to receive VA health care services. If enacted, this measure would allow VA medical treatment to be provided to all service-connected disabled veterans of the United States Armed Forces.

Although not specifically referred to in the bill language, this change would primarily affect a group of approximately 1,200 Canadian citizens who incurred service-connected disabilities while serving as members of the United States military forces in Vietnam.

Because these individuals have disabilities incurred in a war in which Canada did not official participate, these veterans can only obtain needed medical care at their own expense or by traveling to the United States to seek care in a VA facility which, in many instances, is not possible nor feasible.

In effect, current statutory construction bars -- by the citizenship requirement -- the provision of VA health care services to this group, and others, of foreign nationalities who were disabled in line of duty while serving with the United States Armed Forces.

The DAV fully supports S. 894 from an equity standpoint, as well as considering the very close ties between our country and our northern neighbor.

S. 915

Introduced by yourself, Mr. Chairman, this measure would amend Section (d) of Section 4114, Title 38, United States Code, to authorize the CMD to waive state licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in direct patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country.

The DAV has no mandated position on this measure.

S. 939

This measure, introduced by yourself, Mr. Chairman, seeks amendment to Title 38, United States Code:

* Section 603(a)(3) authorizing the VA to provide emergency hospital care in private facilities for veterans receiving VA sponsored (contract) nursing home care in facilities geographically distant from VA medical centers;

* Section 620(a)(2) providing a higher per diem rate for providing VA sponsored care in Alaska and Hawaii, helping to assure the VA's ability to provide such care;

- Section 624(b) deleting the citizenship requirement in order to receive VA health care services (similar to S. 894); and

- Section 603(a) by adding a new paragraph authorizing the VA to contract for care for a veteran deemed to require a period of hospitalization for the purpose of observation and examination to determine eligibility for a VA benefit.

Mr. Chairman, although the DAV has no official position relating to this measure, we are supportive of its enactment.

S. 1062

This measure proposes, by appropriate amendment to Section 4106(b), Title 38, United States Code, to clarify the authority of the CMD or designee regarding disciplinary actions on certain probationary Title 38 health care employees.

We have no official position regarding this measure.

S. 1063

This measure, through appropriate amendment to Title 38, United States Code, proposes to clarify the time limit (six years), regarding the statute of limitations applicable to suits brought by the United States to recover the costs of providing VA health care services to those nonservice-connected disabled veterans having private health insurance; and to clarify and amend the administering of tort claims.

Mr. Chairman, the DAV has no official position regarding this measure.

S. 1065

This measure proposes, by appropriate amendment to Section 4107, Title 38, United States Code, to provide "on call pay" to civil service health care employees appointed pursuant to Title

5, United States Code, or Section 4104(3), Title 38, United States Code.

As we understand it, Mr. Chairman, cost savings will occur by providing "on call pay" instead of the more expensive "stand by pay" currently required to be furnished those Title 5 employees. Because of this and the feeling that patient care will not be placed in jeopardy, we are able to support this measure.

S. 1089

This measure seeks appropriate amendment to Title 38, USC, to improve the State Veterans Home Grant Program.

As you are aware, Mr. Chairman, Public Law 99-576 substantially revised then existing provisions of law governing the award of grants under this program. Current law mandates the VA to award grants according to a prioritized list of grant projects to be established as of July 1st of each year. The previous practice of awarding grants in order of the date application was received, no longer is permissible.

As we understand this measure, no authority currently exists for the VA to award construction grants during the period July 1, 1987, to October 1, 1987. Lacking this authority means that some states with long-pending applications, who have been advised by the VA of the availability of federal funding for their projects and who, as a result of such notification, have incurred substantial costs as a result of that notice, may not be provided with federal funds.

The end result will be that those states will forfeit the substantial funding already dedicated for a needed project for no other reason than what appears to be a technical mishap. Additionally, various states may thus find the grant program unattractive.

S. 1089 would authorize the Administrator to award a grant between June 30, 1987, and October 1, 1987, if he had previously notified the state of the availability of federal funds for the project. Mr. Chairman, as we see a technical problem in this area, the DAV is supportive of enactment of this seemingly equitable amendment.

S. 1125

This measure proposes a modification of the structure of the Office of the Chief Medical Director; to clarify procedures for removal for cause of certain employees; to authorize the use of director paygrade within VA Central Office; to guarantee appointees to executive medicine positions, in the event their position were abolished, restoration rights to the position they previously held; provide that certain persons who are not physicians or dentists, would be eligible for bonuses and rank awards under the Senior Executive Service System; and to raise the base pay for the position of Associate Deputy Chief Medical Director.

Mr. Chairman, except for that portion of the bill dealing with the reorganization of the Department of Medicine and Surgery (as previously discussed in reference to Section 8 of S. 6), we have no official position regarding this measure.

S. 1136

This measure would, by appropriate amendment to Section 4110, Title 38, USC, limit the appointment of disciplinary boards to cases where the proposed penalty is removal, suspension of more than 14 days or demotion involving loss of grade or pay; allow for delegation of the CMD's authority to appoint disciplinary boards to other officials; and allow the

CMD to re-delegate authority delegated to him by the Administrator to appoint a chairman and secretary to the board and to receive and act upon recommendations of the board.

Mr. Chairman, the DAV has no position regarding this measure.

That completes our statement, Mr. Chairman. We wish to again thank you and the members of the Committee for allowing us the opportunity to present the views of the DAV on these important issues.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

LEGISLATION AFFECTING VETERANS HEALTH AND HEALTH RELATED PROGRAMS

WASHINGTON, D.C. May 21, 1987

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to various pieces of legislation affecting veterans health and health related programs. The VFW wishes to thank the Chairman and members of this Committee for conducting this hearing addressing these numerous legislative initiatives affecting the health care provided to this nation's veterans.

The first bill under consideration today, S. 6, "Veterans Health Care Improvement Act of 1987," introduced by the Chairman of the Senate Veterans' Affairs Committee, Alan Cranston, along with Senators Matsunaga, DeConcini, Mitchell, Rockefeller, Graham and Lautenberg, contains numerous provisions pertaining to veterans health care. This legislative initiative is concerned with the maintenance and improvement of the VA's ability to meet the health care needs of our nation's veterans and their dependents. It is also the stated purpose of this bill to achieve these improvements in VA programs

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without incurring any significant new costs. The Veterans of Foreign Wars is, of course, supportive of making the VA more efficient and effective so that it may better serve this nation's veterans. However, we remain concerned that the VA be provided with sufficient resources to properly fulfill its mandate. Management initiatives alone will not suffice. We will now review this bill various provisions.

Section 2 of S. 6 would authorize the VA to furnish services to help a female veteran or a male veteran's spouse to achieve pregnancy in cases in which the veteran's service-connected disability impairs the procreative ability. As we have stated in the past, the VFW maintains that such a program is long overdue and we welcome its implementation by the VA.

Section 3 authorizes the Administrator, utilizing Veterans Administration (VA) facilities, to furnish domiciliary care to a veteran who has a service connected disability or is incapacitated from earning a living and has no adequate means of support for the purpose of providing treatment or rehabilitation to such a veteran. The VFW supports this provision.

Section 4 pertains to the extension of readjustment counseling eligibility. Section 4(a) would make two additional categories of individuals eligible for such services, namely, individuals who served during the Vietnam era but who are still on active duty--thus are not eligible as veterans under Title 38; and those with certain service after May 7, 1975. Under this change the Administrator, after consultation with the Secretary of Defense, would be authorized to specify what service periods and specific locations where U.S. armed forces were under hostile fire will be qualifying service for readjustment counseling purposes. The VFW is supportive of this change.

Section 4(b) would extend from April 1, 1987 to October 1, 1988, the time by which the Administrator must submit the "Vet Center Transition Planning Report." Section 4(b) would also make a technical amendment by referring to

Vet Centers as a program providing readjustment counseling through "Vet Center" and define that term as "facilities which are operated by the Veterans Administration for the provision of services under this section and which are situated apart from the Veterans Administration general health-care facilities." The VFW supports the changes contained in this section. We believe that such readjustment and psychological counseling is still very necessary for certain veterans of the Vietnam era and of the post-Vietnam era who have been subjected to hostilities. We only asked that the language be included to require the Department of Defense (DOD) to share the cost with the VA in those cases where such counseling is provided to a member of the Armed Forces.

Section 5 would provide for a pilot program for a noninstitutional alternatives to institutional care. The VA would be required to conduct a four year pilot program with not less than five and no more than ten demonstration sites to evaluate noninstitutional alternatives to institutional care. The VA would be called upon to provide certain veterans with medical rehabilitative health services itself and by contracting with non-VA entities with health relative services. The VFW supports this proposal to supply health care in a noninstitutional setting to eligible veterans who otherwise would be in need of VA hospital, nursing home or domiciliary care. We believe this approach would allow more veterans to receive better care for less money while allowing the veteran patient and his or her family an improved quality of life.

Section 6 of the bill would eliminate the Administrator's authority to prescribe limitations on the furnishing of VA health care. The Veterans of Foreign Wars does not believe the Administrator of Veterans' Affairs should have the authority or even the appearance of the authority to reverse the will of the Congress in the area of veterans' benefits and entitlements. It is a sad, but well known fact, that there are those who are actively engaged in trying to reduce veterans' programs and the fact that the statutory authority may exist for the Administrator to restrict veterans health-care is not acceptable. Thus we support this section to eliminate this authority.

Section 7 would increase the authorized per diem payments to State Homes for care provided to eligible veterans. Home program per diem rates would be increased from $7.30 to $8.70 for domiciliary care, and from $17.05 and $15.25 to $20.35 for nursing home and hospital care, respectively. The VFW strongly supports increasing these per diem rates which have not been increased since 1985.

Section 8 would amend section 4103 of Title 38, relating to the organization of the Office of Chief Medical Director (CMD), so as to establish one new position in that office, to provide new flexibility in the appointment of individuals to new positions in the CMD's office, and to make various technical changes in the section. More specifically, the single Associate Deputy Chief Medical Director (ADCMD) position would be divided into two positions--an ADCMD for operations, responsible for overseeing current operation of DMS and an ADCMD for program development and planning, responsible for overseeing planning and program management matters. The second prinicipal category change would authorized the Administrator to appoint in addition to physicians certain non-physician, health care professionals--dentists, registered nurses, optometrists, pharmacist, pathologist, and psychologist--to various positions in the CMD's office. Thus these non-physician professionals who would be eligible to serve in either ADCMD position as well as being made eligible to be appointed to the positions of Assistant CMD and Medical Director. The VFW believes this provision would give the Chief Medical Director more flexibility and authority to manage his department. We have no objections with respect to authorizing a maximum of two Associate Deputy Chief Medical Directors. One concern, however,is that the number of Assistant Chief Medical Directors be maintained at eight, with special emphasis on maintaining the position of Assistant Chief Medical Director for Geriatrics and Extended Care. There is now a bill under consideration in the House, H.R. 2010, which would eliminate this crucial position. Considering the vitual role geriatrics will be playing in the future, we cannot understand why the VA would eliminate this crucial position.

Section 9 of S. 6 would prohibit the Administrator from taking any action to declare as excess to the needs of the VA, to transfer to another federal agency or otherwise to relinquish VA interest in any portion of certain lands of VA medical centers in southern California--46 acres at Sepulveda and 109 acres at West Los Angeles. The VFW is of the opinion that this valuable VA land will be needed in the future. Therefore, we support this provision.

The 10th and final section of this bill would prescribe that no later than March 1987 the Administrator of Veterans' Affairs shall submit to the Committee on Veterans' Affairs of the Senate and House of Represensatives a report regarding the VA's activities, and the success of those activities. This is intended to promote increased efforts by affiliated medical and other health professional training schools in training health-care professionals to care for older patients, and research in the aging process and diseases and disabilities associated with aging. This would be done in order to gauge the extent to which the VA has an impact on affiliated institutions with regard to their training and research efforts in the area of aging and with an eye toward motivating such health-care training institutions to increase their efforts in the areas of training health-care professionals in the care of older patients and research relating to aging issues. In light of the enormous challenge facing this nation in caring for its aging population with special emphasis on caring for the much more rapidly aging veteran population, the VFW supports this provision.

The next bill under consideration today is S. 216, a bill to increase per diem rates paid to States for providing care to veterans in State Homes, introduced by Senator Mitchell along with Senators Cranston and Matsunaga. The effect of this bill would be identical to section 7 of S. 6, in that the per diem rates would be increased to $8.70 for domiciliary care and $20.35 for nursing home and hospital care, respectively. As indicated earlier, the VFW supports this initiative.

The next bill under consideration, S. 279, introduced by Senator DeConcini along with Senators Cranston, Matsunaga, Mitchell, Rockefeller and Lautenberg, would amend Title 38 USC to postpone the transition period for the VA Vet Center Program and to delay the due date of certain reports related thereto; and to delay the due date of a report on post-traumatic stress disorder among Vietnam-era veterans, and for other purposes. This bill calling for continued operation of the VA Vet Center Program is the same as Section 4 of S. 6 and as was mentioned earlier, it enjoys the support of the Veterans of Foreign Wars.

Another bill under consideration today is S. 631, "Veterans Administration Procurement Improve Act of 1987," sponsored by the ranking minority member of the Senate Veterans' Affairs Committee, Senator Murkowski along with Senators Stafford and Simpson. This bill would provide that no later than three years after the date of the enactment of this act the Administrator of Veterans Affairs shall develop an agency-wide plan for the standardization of all medical and pharmaceutical supplies procured by the VA. This plan is to provide for the procurement of both generic medical and pharmaceutical supplies. Inasmuch as such a standardized procurement policy could provide for uniformly high quality of supplies throughout the VA along with achieving cost savings through competitive bidding, the VFW would not oppose this bill. Our primary concerns would be the timeliness of this procurement process and that the particular medical and pharmaceutical supply needs of certain localities could be met through such a nation-wide program.

S. 713, "Veterans Administration Registered Nurse Variable Incentive Bonus Act of 1987," introduced by the ranking minority member of the Senate Veterans' Affairs Committee, Senator Murkowski, would amend Title 38 USC to facilitate the recruitment of registered nurses by the VA. This bill would require the Administrator to pay a bonus in an amount not to exceed $20,000 to any registered nurse employed on a full time basis by the VA for a specified period of not less than three years and who serves during that period in a specified geographical location or a professional specialty for which the Administrator has determined that there is a significant recruitment and retention problem. Such a bonus would not be payable to any registered nurse who has received a training scholarship which obligates such nurse to serve in the VA for a specified period of employment. At least once each year the Administrator would be required to determine the specific geographical location and professional specialties in which there are significant problems recruiting and retaining nurses. In light of the fact, the VA is now known to be having serious problems in recruiting and retaining registered nurses in certain specialty areas and in certain parts of the country. The VFW supports this proposal to utilize bonuses in recruiting and retaining this desperately needed health-care professionals.

S. 894, introduced by the ranking minority member of the Senate Veterans' Affairs Committee, Senator Murkowski, would allow the VA to provide health care to non-U.S. citizens who were disabled while serving in the U.S. Armed Forces during a period of war. It is our understanding this legislation is primarily targeted to a small group of Canadian citizens who were disabled while serving with U.S. forces in Vietnam. The VFW supports the enactment of S. 894.

S. 914, the "VA Health Care Amendment Act of 1987," would expand the term "nursing home care" to include both skilled and intermediate levels as is now provided by the VA; make domiciliary care eligibility requirements the same for all veterans; establishes specific legal authority for the VA to establish off-station therapeutic recreational activities; and, would make an individual disabled by VA treatment, examination or vocational rehabilitation eligible for outpatient care as are service-connected disabled veterans.

It is our understanding this VA initiative is intended to expand eligibility to the domiciliary program as well as the areas of service provided to veterans; therefore, we support S. 914.

S. 915 would authorize the Chief Medical Director to waive state licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care and for licensed or vocational nurses and physical therapists to be employed in a foreign country. Under current law, health-care professionals must be licensed or registered in a state in order to be eligible for appointment in the VA's Department of Medicine and Surgery.

It is our understanding the primary intent of this legislation is to promote the VA's medical research and education programs, and that these individuals would not be involved in any patient care. The bill would also waive the state licensing requirement for vocational nurses and physical therapists to be employed in a foreign country. The only foreign country where the VA currently has a health-care facility is in the Philippines. The VFW supports S. 915.

S. 916 introduced by request by the Chairman of the Senate Veterans' Affairs Committee would amend Title 38 USC to authorize the Administrator to assist Members of Congress in providing Title 38 benefit information to their constituents, and to conduct authorized field examinations and investigations. Furthermore, the Administrator would also be authorized to release the name or address of any present or former member of the Armed Forces or dependent of a present or former member of the Armed Forces if the release is necessary to conduct a field examination, investigation or other inquiry for Title 38 benefit programs or if the information is necessary to enable the Inspector General to perform his duties as authorized by Title 5 USC. The Veterans of Foreign Wars is concerned that the utmost diligence be applied to ensuring that such authority be not misused or used for other than the aforementioned specified purposes. We also insist that in the course of a field examination that the names and addresses of involved veterans or beneficiaries not be unnecessarily disclosed to various individuals such as neighbors, merchants, and relatives in the course of the investigation. We also oppose that such information being provided to consumer reporting agencies and others for the purpose of non-VA debt collection. We additionally point out that in this age of computerized listing and information sharing any such information reported to consumer reporting agencies for purpose of VA debt collection could easily be incorporated into a non-VA debt collection effort. Such abuse must be stringently guarded against.

S. 939, the "Veterans' Health Care Benefits Administration Act of 1987," would generally liberalize the access requirements of eligible veterans to certain health-care facilities. The proposed legislation would allow the VA to pay for emergency care needed by VA patients in private nursing homes in the same manner that it now pays for such care for its patients in VA or other Government facilities; would set a higher index rate in those states without a general hospital (Alaska and Hawaii); would allow the VA to provide health care to non-U.S. citizens who were disabled while serving in the U.S. Armed Forces during a period of war, primarily a group of approximately 1,200 Canadian citizens who were disabled while serving with U.S. forces in Vietnam; would clarify the VA's authority to provide medical services to veterans participating in a vocational rehabilitation program outside the United

States; and would in certain instances, authorize the VA to contract for hospital admission for observation and examination in order to determine a veteran's eligibility for compensation or pension when the local VA medical center is unable to provide such services. The VFW believes the provisions of S. 939, again, liberalize eligibility requirements and would only affect a small number of deserving veterans who would otherwise not be eligible for VA health care. Therefore, we support the enactment of S. 939.

S. 1062, would clarify the authority of the Chief Medical Director or designee regarding disciplinary actions of certain probationary Title 38 health-care employees. This bill would simply clarify the intent of Congress that the Administrator has the power to prescribe by regulation the procedures to be followed by the Professional Standard Boards, circumstances in which Board proceedings may be initiated and that final action in the review process should be taken by the Chief Medical Director. The VFW supports S. 1062.

S. 1063 was introduced by the Chairman of the Senate Veterans' Affairs Committee, Senator Alan Cranston, by request of the Administration. H.R. 2013 was introduced by the Chairman of the House Veterans' Affairs Committee, G. V. "Sonny" Montgomery, and the ranking minority member, Gerald Solomon, at the request of the Administration. These two bills are indentical and call for the amendment of Title 38 USC, principally to make selected improvements in the administering of Tort Claims and hospital cost collection.

These bills are meant to clarify the statute of limitations applicable to suits advanced by the Federal Government to recover the cost of VA health-care furnished for nonservice-connected disabilites under the provisions of Title 38 USC, section 629. The bill would establish a six year statute of limitations and designate the day on which one statute begins to run: the last day of treatment for which recovery is sought.

S. 1063 and H.R. 2013 would also amend section 4116 of Title 38 USC, as it relates to immunity from personal liability for medical malpractice for VA medical personnel. This measure would allow claims against the United States under the Federal Tort Claims Act as a result of negligent or wrongful acts of VA personnel furnishing medical care or treatment in the Department of Medicine and Surgery, including assault, battery, libel, slander, abuse of process, malicious prosecution, false arrest, false imprisonment, misrepresantation, or deceit. This bill would extend to VA health-care personnel the same degree of protection as is currently afforded to similar personnel in other government agencies.

The final provision under S. 1063 and H.R. 2013 would permit the VA Administrator to settle administrative Tort Claims to the extent delegated by the Attorney General. However, settlements in excess of the delegation would continue to be subject to approval by the Department of Justice.

These provisions wouldn't have any significant impact on the VA appropriation's account. The added protection to VA health-care personnel would entail minimal costs since the problem it would alleviate arises only in a limited number of cases.

The Veterans of Foreign Wars believes these bill are intended to improve Title 38 and would have no objection to their passage. They would clarify the st~~atut~~e of limitations as they apply to the VA's ability to recover the cost of VA health-care; expand the immunity from personal liability for VA health-care personnel, as is already afforded health-care personnel of other federal agencies; and remove a statutory limitation on the authority of the Administrator to settle administrative Tort Claims. This expanded settlement authority should lead to a speedier recovery for the veteran claimant.

S. 1064 and H.R. 2001 both provide for the extension of the adult day health-care program and authorize contract halfway house care for veterans with chronic psychiatric disabilities. Since 1985, the VA has been furnishing adult day health-care and this program is due to expire on September 30, 1988.

We support the provisions authorizing the VA to establish a pilot program to provide contract treatment in halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities for any eligible veteran who is suffering from a chronic psychiatric disability. The VFW supports this provision inasmuch as we believe, in many cases, veterans are being discharged from VA facilities with no one to assist them in their home recovery period. S. 1064 and H.R. 2001 will provide much needed assistance to these veterans.

S. 1065 would amend Title 38 USC to authorize the Administrator of Veterans' Affairs to provide "on-call" pay to certain civil service health-care personnel. Currently, the VA must place health-care support personnel such as X-ray, laboratory, operating room and other technicians in a "standby" duty status to ensure they would be available if a medical emergency should arise and to pay them "standby" duty premium pay whether they actually work or not. Those employees in an "on-call" status are not required to be at their assigned duty stations but must arrange for others to respond to a call or leave a telephone number where they may be reached. Employees who are "on-call" do not receive pay; however, if called back to work they do receive overtime pay for the time they actually worked. The VFW supports S. 1065.

By request, the Chairman and ranking minority member of the House Veterans' Affairs Committee introduced H.R. 2009. This bill would limit the types of proposed disciplinary actions in which disciplinary boards function and allow for the delegation of authority of the Chief Medical Director in certain situations.

H.R. 2009, in effect, grants the Chief Medical Director the flexibility to preside over certan disciplinary actions without having to refer such action to a disciplinary board. The VFW considers this legislation a liberalization of administrative policy and has no objection to its enactment.

H.R. 2010 would authorize the modification of the structure of the Office of the Chief Medical Director; clarify procedures for removal for cause of certain employees; and authorize the use of the Director Pay Grade within the VA Central Office.

The VFW believes H.R. 2010 will give the Chief Medical Director more flexibility and authority to manage his department. We have no objections to the bill's provision authorizing a maximum of two Associate Deputy Medical Directors. We do, however, have strong reservations about section "B" of the bill which would reduce from eight to seven the number of Assistant Chief Medical Directors. What is particularly distrubing to the VFW is the fact that H.R. 2010 does not specifically require an Assistant Chief Medical Director for Geriatrics and Extended Care. Considering the vital role geriatric care will be playing in the near future we cannot understand why the VA would eliminate this crucial position. While the VFW will not oppose H.R. 2010, we cannot stress strongly enough our recommendation that specific language requiring and Assistant Chief Medical Director for Geriatrics and Extended Care be included in H.R 2010.

Mr. Chairman, this concludes my testimony, thank you and I will be happy to respond to any question.

PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

STATEMENT
OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
S. 6, "VETERANS' HEALTH CARE IMPROVEMENT ACT OF 1987"

TO AMEND TITLE 38, U.S. CODE, TO IMPROVE VARIOUS ASPECTS OF VA HEALTH-CARE PROGRAMS; TO PROVIDE CERTAIN NEW CATEGORIES OF PERSONS WITH ELIGIBILITY FOR READJUSTMENT COUNSELING AND TO POSTPONE THE TRANSITION PERIOD FOR THE VET CENTER PROGRAM; TO AUTHORIZE ESTABLISHMENT OF A PILOT PROGRAM FOR THE FURNISHING OF NONINSTITUTIONAL CARE TO CERTAIN VETERANS; AND TO INCREASE PER DIEM RATES PAID TO STATES FOR PROVIDING CARE TO VETERANS IN STATE HOMES; AND TO PROHIBIT THE EXCESSING OF CERTAIN VA PROPERTIES; AND TO PROMOTE GREATER EMPHASIS ON GERIATRIC TRAINING AND RESEARCH AMONG AFFILIATED HEALTH-PROFESSIONAL TRAINING INSTITUTIONS

S. 216 - Amend Title 38, U.S. Code, to increase the per diem rates paid to states providing care to veterans in state homes
S. 631 - Improve procedures for the procurement of medical and pharmaceutical supplies by the Veterans Administration
S. 713 - Amend Title 38, U.S. Code, to facilitate recruitment of registered nurses by the VA
S. 1195 - Veterans Administration Health Personnel Recruitment and Retention Act of 1987
- Administration-requested and other health legislation
- FY'88 major VA medical construction projects

MAY 21, 1987

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300
Chartered by the Congress of the United States

Mr. Chairman and Members of the Committee, on behalf of the members of Paralyzed Veterans of America, a Congressionally chartered veterans' service organization, I want to thank you for this opportunity to present our views regarding a package of various legislative health care proposals. I am Frank R. DeGeorge, Associate Legislative Director.

PVA appreciates the Committee's efforts to conduct this important hearing and ongoing effort to improve VA health care Programs.

S. 6 - "VETERANS' HEALTH-CARE IMPROVEMENT ACT OF 1987"

PVA appreciates and applauds the Honorable Alan Cranston, Chairman, Senate Committee on Veterans' Affairs, for introduction of S. 6. This bill would amend or repeal certain sections or provisions of Title 38, United States Code. PVA provides comments addressing each issue section by section as deemed appropriate.

SEC. 2 - SERVICES TO OVERCOME SERVICE-CONNECTED DISABILITIES AFFECTING PROCREATION

PVA is particularly pleased to address your provision Mr. Chairman, to provide procreative services to overcome service-connected disabilities preventing pregnancy. PVA has worked a long time to seek legislative recourse to what we believe is merely a clarification of existing VA authority. We appreciate the opportunity to work with you and your staff to bring about this necessary provision.

All of PVA's members are veterans who have experienced spinal cord injury or dysfunction. Spinal cord jnjury can, and often does, result in a residual loss of procreative ability as a secondary impairment from the primary injury. For many of our members, the inability to experience the fullness of life brought about by the growth and expansion of one's immediate family has been a major psychological barrier. PVA's members are faced first with a catastrophic disability and then with the realization that this disability could deny them one of life's greatest rewards, children.

PVA has, since the formation of its first chapter nearly forty years ago, been an advocate for the expansion of roles for the disabled. Today, with ever expanding medical technology, our members can expand their lives even further, as fathers, mothers, grandfathers and grandmothers. We believe that parenting is a very personal experience, and our members should have that opportunity.

The Office of Technology Assessment is compiling a report on infertility with a chapter on veterans. It is due to be released later this year. A draft version of this report finds that the actual numbers of veterans eligible for procreative services is quite small. This group is further reduced by the number of eligible veterans who would actually utilize this benefit should it become available. The report identifies in 1985 that there were approximately 15,651 male veterans under the age of 55, and between 1,200-1,300 female veterans between the ages of 17 to 44 years, on the VA records, who have a service-connected medical condition that could cause infertility.

Mr. Chairman and Members of the Committee, PVA believes that the number of veterans actually availing themselves of these treatments for infertility are so small that the associated costs would be negligible in providing these services. We ask all Members of this Committee to support this provision which will have limited but significant impact for a small number of deserving and eligible veterans.

Sec. 3 _ ELIGIBILITY FOR DOMICILIARY CARE

This section would extend authorization to provide "domiciliary care to a veteran." PVA believes that by expanding the eligibility provisions of this program will, in part, address the plight of certain homeless veterans needing shelter and medical support, and, in the future, provide institutional care for certain older veterans.

PVA supports this provision including the proposed revised eligibility criteria which would provide domiciliary care to: 1) service-connected disabled veterans, and, 2) veterans incapacitated from earning a living and has no means of support. We find this criteria totally consistent with past and present VA eligibility standards.

Sec. 5 - PILOT PROGRAM OF NON-INSTITUTIONAL ALTERNATIVES TO INSTITUTIONAL CARE

PVA supports this provision which calls for a pilot program to provide non-institutional contract care, treatment, and rehabilitative services in halfway houses, therapeutic communities and psychiatric treatment centers for homeless veterans. We believe the program can be of benefit to significant numbers of homeless veterans currently suffering untreated chronic psychiatric disorders. The program can also provide an additional community based treatment methodology for veterans facing discharge as inpatients from VA psychiatric facilities who could become homeless without any other means of transitional treatment and access to support programs to meet their physical and mental health care needs.

We believe the Committee has found, if properly controlled and monitored, a concept, along with the expansion of eligibility for domiciliary care and other initiatives, to add to the VA's "tool chest" in caring for the growing numbers of homeless veterans in the United States today.

Sec. 6 - RULES AND REGULATIONS RELATING TO HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE.

This section would revise the authority of the Administrator in proscribing rules and regulations governing the provision of VA health care to insure such action is consistent with existing law. The section would amend Section 621 of Title 38, U.S.C. to correct what PVA believes to be a long-standing discrepancy. Current law gives the Administrator unilateral authority to proscribe regulations governing the furnishing of care to include regulations which could even limit hospital, nursing home and domiciliary care for veterans. We fully support this revision, particularly in light of the health care eligibility reform designed and approved by the Congress last year in P.L. 99-272. The new law, once again, has established the authority of the Congress in setting forth clear eligibility criteria for veterans' health care. We believe it is important for all Sections of Title 38 U.S.C. to concur with this line of authority with regard to the role and function of the VA Administrator.

Sec. 7 - INCREASE IN PER DIEM RATES FOR CARE IN STATE HOMES

PVA supports Sec. 7, which recognizes the need for an increase in the per diem rate paid by the Veterans Administration for veterans being cared for in State Veterans' Homes. The increase, the first in three years, would raise the daily Veterans Administration support for domiciliary residents from $7.30 to $8.70. However, please be aware that PVA has testified and supported similar legislation in the House Committee on Veterans' Affairs. This measure H.R. 1659 provides for daily support in the amount of $9.00 per day for domiciliary care. The legislation would also combine the per diem rates paid for nursing home care and hospital care, currently at $17.05 and $15.25, respectively, to one increased rate of $20.35 per day for both. Thirty-five states have State Veterans' Homes, domiciliaries or hospitals which cared for well over 17,000 veterans in Fiscal Year 1986.

Sec. 8. ORGANIZATION OF THE DEPARTMENT OF MEDICINE AND SURGERY

PVA supports revising the qualifications of all appointees under Section 4103 to include persons, each of whom shall be qualified in the administration of health services. We believe this qualification to be an important element in the management of the Department of Medicine & Surgery. However, PVA opposes the total removal of the physician and/or dentist limitation.

PVA recognizes the quality and expertise that can be afforded to DM&S through the appointment of certain non-physician health professionsls, but we would prefer some system of prior notification of the Administrator's intention to appoint those persons not meeting the physician and/or dentist requirements. PVA would recommend the prior submission of these applicants' qualifications to the Chairmen of the Committees on Veterans' Affairs and ideally the respective Ranking Minority Members for informal concurrence and approval. PVA recognizes that in certain instances, positions within the Office of the Chief Medical Director could be appropriately performed by non-physician health professionals. Therefore, we support the intent of the legislation.

We also support the provision in this section which calls for a licensure requirement in appropriate service fields as a prerequisite to these and all positions requiring specialization in the Office of the Chief Medical Director. We support the provision calling for one additional Associate Chief Medical Director.

Sec. 9. PROHIBITION AGAINST EXCESSING OF CERTAIN VETERANS ADMINISTRATION PROPERTIES

PVA supports this provision which would prohibit the Administrator from excessing land and improvements at the VA Medical Center, West Los Angeles, California and the VA Medical Center at Sepulveda, California. Short term and questionable profit to the federal government from the disposal of this property does not take into account the future needs of the VA and the potential value of the property to the agency in years to come. For these reasons, PVA believes that extreme caution should be exercised in the consideration of the disposal of this or any VA owned property.

S. 631 - PROCUREMENT REFORM

PVA supports S. 631, legislation to improve the procedures for the procurement of medical and pharmaceutical supplies by the VA. At a time of tight budgets and increasing demand on the VA's medical system, PVA believes that every effort should be made to seek reasonable management efficiencies in order to stretch the agencies health care dollar. The legislation was based, in part, on recommendations from the VA's contracted study on procurement conducted by Coopers and Lybrand. The study concluded that significant savings could be found if the VA were to standardize procurement procedures for medical and pharmaceutical supplies requiring individual VA medical center to purchase items primarily at bulk discount prices through its own major supply depots. Currently 38 percent of medical supplies and 17 percent of pharmaceuticals are purchased by medical centers through local procurement. The study estimated that items obtained through this method are 25 to 50 percent higher in cost than items purchased through supply depots.

We believe the legislation can bring millions of dollars in savings to the VA. At the same time, it gives the individual medical center certain procurement flexibility in stating that up to 20 percent of total purchasing could still be obtained through local contract to cover certain supply needs not readily met by national supply depot contract. The legislation would also give a medical center the ability to purchase locally to meet emergency needs. PVA would like to recommend, however, that further clarifying language be supported in the legislation which would more fully define the nature of exactly what kind of medical and pharmaceutical supplies are to be covered by the bill. We are concerned that among the millions of items purchased by the VA in any given year, there are certain specialty items, devices and prostheses, which are not easily obtainable by national contract because of their design, purpose, or quantity needed. PVA believes it would be helpful to separately identify such items from the general definition of medical and pharmaceutical supplies to avoid any potential delay or inconvenience in the provision of the items to the veteran patient.

S. 894 - "To authorize the Administrator of Veterans' Affairs to furnish certain hospital care and medical services for service-connected disabilities for certain veterans."

PVA supports S. 894, introduced by Senator Frank Murkowski. We believe that it is only fair and equitable that service-connected disabled veterans sojourning or residing abroad be afforded the same eligibility and access to health care services as those veterans with the same eligibility residing in the United States.

S. 1059, "To terminate the application of certain Veterans' Administration regulations relating to transportation of claimants and beneficiaries in connection with Veterans' Administration medical care.

PVA appreciates Senator Daniel Patrick Moynihan's concern for veterans in his design and introduction of this legislation. It is obvious that VA regulations limiting Beneficiary Travel have impacted negatively on veterans who do not have the ability and or the resources to travel to a VAMC for needed medical care treatment. PVA would encourage this Committee to entertain corrective legislation that would direct the VA to modify and improve these regulations.

RECRUITMENT AND RETENTION OF VA HEALTH-CARE PROFESSIONALS

Mr. Chairman, PVA is pleased to address this Committee's legislative efforts to ease the acute retention and recruitment problems being experienced by the VA's Department of Medicine and Surgery. We commend you, Mr. Chairman and you Senator Murkowski, for your commitment to this important issue and for the introduction of your two respective bills.

Mr. Chairman, your bill, the "Veterans' Health-Care Personnel Act of 1987," is a fine, well-crafted legislative work. This measure effectively addresses some of the VA's retention and recruitment problems, while at the same time avoids overmanaging the Agency. PVA fully supports your efforts. The provisions contained within the bill are not only necessary, they are long overdue.

The provision to move pharmacists and occupational therapists into the Title 38/Title 5 "hybrid" category will provide the VA with greater flexibility in appointments and pay matters. It will also allow these same professionals access to the Health Professionals Scholarship Program and afford them the opportunity for professional advancement. The VA needs this recruitment and retention tool in order to become a competitive employer and to increase the job satisfaction of its current employees.

The "Veterans' Health-Care Personnel Act of 1987," also addresses the critical nursing shortage in the VA. Providing this professionals group with weekend premium pay, tuition reimbursement and representation on all VA health care policy-making and fiscal committees, just makes good sense. These same benefits have been offered in the private sector, and other benefits as well, for a number of years. When coupled with Senator Murkowski's bill, S. 713, "The VA's Registered Nurse Variable Incentive Bonus Act of 1987," PVA believes we have the beginnings of a very sound legislative package of long and short-term resolutions to the VA's professional nursing shortage.

PVA does, however, have some remaining concerns with the legislation as written. First, PVA wants assurances that this comprehensive package of benefits will enhance, not replace, administrative efforts on the part of the VA, to address this issue. Secondly, the Committee should be careful not to overlook the severe shortage of licensed practical nurses and nursing assistants as certain additional benefits under consideration are applicable only to Registered Nurses. PVA believes these nursing personnel are also essential in providing quality care to our nation's veterans.

A program to provide tuition reimbursement, as well, is an essential component in a comprehensive benefits package for nurses and other health professionals. PVA is pleased to note that the VA had already implemented a tuition assistant program this year. We commend their efforts. PVA is concerned, though, that once the VA as an employer offers a particular benefit, it is very detrimental to then remove that program or benefit due to lack of funding or other reasons. PVA believes that when this tuition reimbursement program is fully operational, every effort, both by the VA and Congress, must be made to ensure its future viability. The VA will rapidly lose credibility as an employer if it offers certain benefits to potential applicants only to deny them at a later date.

Secondly, PVA believes that the tuition reimbursement program itself should be flexible enough to meet a broad range of professional needs. For instance, we believe that continuing education can be both formal and informal. We propose that the VA's tuition reimbursement program, though mandated by Congress, should be designed and defined by the very professionals who will draw upon it for their own professional growth and advancement.

With regard to the Health Professionals Scholarship Program, PVA has two concerns. First, we believe that the requirement to extend the period of payback obligated service to 2 years for every one year of scholarship would limit the effectiveness of the program. PVA believes that enhancement of the VA's overall retention and recruitment efforts will result in satisfied employees who will want to stay with the VA. We believe that requiring 2 years of payback for every educational year will limit the number of students desiring to begin the Program between the Freshman and Junior years.

Secondly, we are concerned that mandating that priority be given to senior level nursing students only will further limit the VA's selectivity of potential applicants. With a shortage of nurses nationwide and an already limited pool of qualified applicants, competition for senior level nursing students is keen. PVA, while recognizing the meritorious intentions of this provision, would prefer to have the application process for the Health Professionals Scholarship Program remain equally open to all eligible students, so as not to place undue restrictions on the VA's recruitment efforts.

PVA strongly supports the extension of this Scholarship Program to other health professionals such as physical therapists. We believe it is an excellent program which should be fully funded year after year.

Mr. Chairman and Members of the Committee, we cannot commend you enough for your efforts on behalf of our membership to solve this perplexing and difficult retention and recruitment problem of the VA. As we have testified previously, we believe that each of these professional groups have unique requirements which result in recruitment and retentions problems specific to that profession. It is therefore clear to PVA that any general, sweeping legislative proposal cannot address the individualized, specific needs of each of these professions. On the other hand, most individualized and specific legislative efforts will be criticized as a congressional attempt at micromanagement. The legislation we are addressing today with very little change, strikes a good balance of combined congressional, administrative and veterans' service organization input. It is this resurgence of commitment which is needed. The combined commitment of the Committees, the Agency, consumer groups such as PVA, and the professionals themselves is necessary in order to engineer a variety of creative solutions which address both long-term and quick-fix results.

CATEGORY A OUTPATIENT CARE

Mr. Chairman, during your deliberations of these important health care amendments, we would appreciate the Committee's consideration of a legislative proposal to correct what PVA considers to be a basic inequity in health-care eligibility provisions.

PVA testified earlier before the Congress that under current law, Category A, nonservice-connected veterans may receive outpatient treatment when it obviates the need for inpatient care, is a follow-up to an episode of inpatient care, or, according to the VA, "if space is available." There is considerable latitude in the exercise of the VA physician's judgement regarding the interpretation of "to obviate the need" for hospitalization. The recent marked reduction in VA inpatient census and length of stay is primarily dollar driven, stemming from the imposition of DRG-based resource distribution and detrimental budgets. Similarly it appears that outpatient care to obviate the need for hospital admission is now more restrictively granted. PVA believes from the position of continuity of care, as well as continuity with other federal health programs, that outpatient services for Category A veterans should be made an entitlement.

Particularly for the chronically ill, medically indigent veteran whose disability is not service-connected, lack of clear access to outpatient services can be most unfortunate, if not dangerous. Such a patient may have the need for ongoing close medical supervision only to be told that hospitalization is not necessary, and therefore VA-furnished outpatient care is not available.

Couple this situation with the current restrictions in beneficiary travel allowances, which will further limit a veteran's physical access to VA health care facilities, and the potential for medical crisis looms great, particularly for older chronically ill veterans. The veteran is likely to have no other means of access to care unless he or she also qualified for Medicaid. The Medicaid patient, incidentally, is provided ambulatory care regardless of inpatient care need -- an arrangement certainly more cost effective than inviting, through patient neglect, a crisis need for hospitalization. However, Medicaid is not an alternative for most indigent veterans under 65 because they do not meet its categorical eligibility requirements. If they are unable to access the VA system, these veterans are likely to add to the uncompensated care burden that providers are increasingly shunning, or to fail entirely to obtain care when it is needed.

The VA health care system has always been distinguished for its ability to provide certain patients a comprehensive, coordinated continuum of care. It is regrettable that P.L. 99-272 did not endorse that concept in the course of realignment of entitlement for Category A nonservice-connected veterans. Unrestricted outpatient care for all category A veterans would make for a better quality of care, simplify administrative management, encourage preventive care, reduce the incidence of acute complication, and -- in the last analysis -- better serve cost containment. Indeed the Congressional Budget Office, in the analysis of the original version of P.L. 99-272, which included full outpatient entitlement, judged it to be a cost saving legislative proposal. We hope the Committee will further review and adopt this additional reform.

VA CONSTRUCTION

The Veterans Administration medical construction budget authority request for Fiscal Year 1988 is $525.7 million, reflecting an increase of nearly $37 million compared with Fiscal Year 1987. In addition, budget authority for $42 million has been requested by the Veterans Administration for the "Grants for Construction of State Extended Care Facilities."

Mr. Chairman, in the absence of a comprehensive system for assessing the total need for new, remodeled or renovated Veterans Administration medical facilities, the Veterans Administration has chosen to propose a modestly increased budget figure for Fiscal Year 1988. As in years past, it is difficult to comment on the adequacy of the construction budget request since a mechanism currently does not exist whereby total facility deficiencies and new requirements can be assessed and a complete list of major and minor construction projects specified.

In response to Public Law 96-22, the Veterans Administration developed a priority listing of ten Veterans Administration medical centers it finds to be most in need of construction. This list, submitted to Congress annually since 1979, has little basis since the Veterans Administration cannot demonstrate a comprehensive assessment of all medical facility construction needs. In addition, the Veterans Administration's Prioritization Methodology, which was developed in response to the directive contained in Senate Report No. 98-506, accompanying Public Law 98-371, is also seriously flawed. This methodology which is to be utilized for assessing the system-wide priorities of the Veterans Administration for construction does not adequately address the comprehensive construction needs of the system.
The intent of this directive was to structure a priority order whereby projects that will correct the most serious deficiencies will be developed first. The Veterans

Administration Prioritization Methodology fails to fulfill that intent since no comprehensive assessment of facility needs exists.

If individual Five Year Facility Construction Plans are as fundamentally flawed as the BAH/RTKL Study indicated, then the VA's annual construction authorization requests have little or no basis. The VA's new Prioritization Methodology simply prioritizes construction requests, not overall construction needs. The BAH/RTKL Study states that, with the exception of projects required to support new programs identified in MEDIPP, little useful information is available for selecting projects and for justifying those decisions. As a result, trade-offs in resource allocation among VAMCs and among different types of projects at any one VAMC are often based on highly subjective evaluations as to where the greatest need exists.

PVA is in the process of requesting a list of VA nursing homes, domiciliaries, and outpatient clinics that have been justified and demonstrated to be needed as a result of the MEDIPP program. This is simply a request for a list of the possible VA construction projects in the three categories -- nursing homes, domiciliaries, and outpatient clinics. In our attempts to clarify this matter, we have been frustrated by claims that the information is embargoed.

This sad truth underscores the urgent need for the timely and proper implementation of the Core Process Recommendations identified in the Booz, Allen and Hamilton/RTKL (BAH/RTKL) "Comprehensive Study of the Veterans Administration Construction Process." Properly implemented, these much needed procedural changes will allow decision-makers to measure the impact of a $525.7 million construction budget on the total Veterans Administration facility need.

PVA's review of the pilot program's statement of task reveals that the most important aspect of the first Core Process Recommendation has been seriously neglected. Specifically, a system for measuring and projecting total Veterans Administration medical facility needs is noticeably absent. The BAH/RTKL Study identifies prerequisite steps in the form of computer system requirements before Facility Development Plans are initiated.

The intent of the FDP pilot program is to access the adequacy of the FDP program methodology and to take corrective action. Yet, the results of the pilot projects will not be available to give substantive feedback to the forty FDP projects anticipated in Fiscal Year 1988.

Last year, PVA testified that the implementation of the BAH/RTKL Core Process Recommendations deserved careful scrutiny because those organizational components which have allowed the facility planning process to become so flawed, have now been given the task of critiquing, interpreting and implementing the same. Our review of these efforts to date confirms that the Veterans Administration simply has not kept abreast of current facility planning techniques nor have they acquired or utilized the professional expertise necessary to perform the task.

PVA recommends to this Committee that immediate action be taken to provide appropriate oversight over Veterans Administration implementation efforts as it relates to the Core Process Recommendations. Recognizing that the reorganization of the Veterans Administration's Construction Program is principally driven by the BAH/RTKL Report, this reorganization and it's relationship to the BAH/RTKL Core Process Recommendations should be demonstrated to this Subcommittee as well as veteran service organizations.

The opportunity for substantive change in the VA Construction Program is upon us. However, this opportunity continues to be overshadowed by bureaucratic reshuffling with no demonstrated relationship to the procedural changes which prompted the reorganization in the first place. The involvement of DM&S through substantive participation in all aspects of the VA Construction Program has yet to be demonstrated.

PVA also recommends that consideration be given for an independent, professional peer review of VA implementation efforts to ensure the proper development of the BAH/RTKL Core Press Recommendations. The American Institute of Architects has expressed an interest in participating in such an endeavor. The opportunity is critically important and should not be left to the discretion of a relatively inexperienced group of VA personnel.

PVA is also deeply concerned that the construction request does not provide funding for new Veterans Administration nursing homes. While the demand for extended care services in the Veterans Administration continues to grow, the lack of construction resources in this area will seriously undermine the Veterans Administration's ability to provide health care services to our aging veterans. While we acknowledge the need to examine other alternatives to nursing home care, attempts to shift the burden of care to public and private health-care providers requires careful consideration since they may be ill-equipped or unwilling to accept this demand.

The Fiscal Year 1988 budget calls for the conversion of 282 existing Veterans Administration hospital beds to nursing home beds. PVA supports this as one of several viable alternatives as long as existing acute care services are not disrupted and the mandated total of hospital and nursing home beds is maintained. In this regard, PVA remains deeply concerned that VA bed levels have, over past years, consistently fallen far short of the 90,000 bed-level mandated by Congress, particularly at a time of rising demand on the system. It is obvious to PVA, however, that the conversion of beds in a given area will not obviate the need for additional acute and nursing care beds in others. In areas of the Sun Belt the demand for both acute and long term care beds exists and conversion is not a viable option. Additionally, care must be taken when conversion is considered so that major conversions at a facility do not disrupt or eliminate the current mix of comprehensive health-care services available to veterans served in that geographical area.

We fully endorse the $42 million in grants included in the budget request for the construction and renovation of state extended care facilities. This program continues to present a unique opportunity for state and federal agencies to share the cost and the challenge of caring for aging veterans.
It must be pointed out, however, that the state grant program is not an alternative to VA nursing home care but an component element in the mix of services needed to meet the demands of the aging veteran population.

The recent study, commissioned by PVA, entitled "Veterans' Health Care: Actions and Interactions," clearly indicates that reducing or eliminating current services will merely result in a "cost avoidance." Shifting the cost burden to other public and private health providers will not result in real savings. The Veterans Administration has the primary responsibility for providing health care to the eligible veteran population. The planning and construction of Veterans Administration nursing homes, as well as all VA facilities, is consistent with the Veterans Administration mission to provide a full range of health care services to our nation's veterans.

PVA strongly recommends that the Committee support additional funding to allow the agency to proceed on schedule with several major construction projects deleted in the Administration's budget submission. We endorse the addition of $15 million for design funds for the clinical addition, renovation of Building 2, and the Spinal Cord Injury Center at the Dallas VA Medical Center. This project has been planned for several years but continues to be deleted by the Office of Management and Budget due to fiscal restraint. The VAMC buildings in Dallas were constructed in 1939 and 1950. Severe space deficiencies and increasing demand for care at Dallas are impairing the VA's mission at this facility. We are hopeful that this project, which includes the new Spinal Cord Injury Center so vital to the needs of our membership, will not be delayed another year at additional cost to the taxpayer and inconvenience to the veteran patient.

PVA is also deeply concerned by the the VA's current policy of denying approval for the construction of VA owned and operated nursing homes. Faced with the demands of a growing senior veteran population, the VA simply cannot ignore this need. For this reason PVA encourages the Committee to support funding for the following planned projects at a total cost of $18 million:

VAMC	Palm Beach, Florida: 240 bed nursing home (design funds)
VAMC	Mountain Home, Tennessee: 120 bed nursing home
VAMC	Tampa, Florida: 120 bed nursing home
VAMC	Wilkes Barre, PA: 60 bed nursing home

As we have stated on prior occasions, PVA appreciates the fact that this Committee has and will provide careful examination of the proposed funding for the Veterans Administration and the needed scrutiny of the Veterans Administration's programs to provide the necessary authorization which you have done in the past. Further, we trust and continue to believe that your commitment to the veterans mirrors the intent of Congress.

CONCLUSION

Again, PVA appreciates the invitation to appear here today; we applaud the efforts of the Chairman and Members of this Committee to address these issues, and, as well, the dedicated efforts of your staff. I will be happy to answer any questions that I can.

ALAN CRANSTON, CALIFORNIA, CHAIRMAN
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ANTHONY J. PRINCIPI, MINORITY CHIEF COUNSEL/STAFF DIRECTOR

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510-6375

July 6, 1987

Mr. David J. Passamaneck
National Legislative Director
American Veterans of WWII, Korea, and Vietnam
4647 Forbes Boulevard
Lanham, Maryland 20726

Dear Dave,

I am enclosing for your review and comment legislation (and introductory statements) introduced on July 1 and June 26 addressing two of the major issues currently facing the Veterans' Administration -- beneficiary travel reimbursement and quality assurance.

S. 1464, the proposed "Veterans' Administration Beneficiary Travel Restoration Act of 1987", is a bipartisan measure which I introduced with Senator Murkowski, the Committee's ranking minority member, and which is cosponsored by 17 other Senators. This bill is designed to provide for the equitable distribution of beneficiary travel payments to all service-connected veterans, to low-income veterans, and to veterans who, because of their rural or remote locations, need assistance to overcome the high cost of travel which hampers their ability to obtain the VA health care to which they are entitled or for which they are eligible.

S. 1443, the proposed "Veterans' Administration Medical Inspector General Act of 1987", which I introduced with Senator Murkowski and 5 other Senators, would provide for the thorough and autonomous investigation of health-care incidents through the establishment of the Office of Medical Inspector General in the Office of the Chief Medical Director and the upgrading of DM&S quality assurance activities by elevating responsibility for such activities to a new Assistant Chief Medical Director for Quality Assurance. The complementary measure, S. 1444, the proposed "Veterans' Administration Assistant Inspector General for Health Care Quality Assurance Review Act of 1987", introduced by Senator Murkowski and myself and 7 other Senators, would enhance the monitoring of quality assurance programs at VA medical centers by proposing the establishment of the position of Assistant Inspector General for Health Care Quality Assurance Review in the Office of the VA Inspector General. Together, these measures are designed to ensure the effective operation of the VA's inspection, quality assurance, and risk management programs by requiring the provision of the funding, staffing, and authority necessary for the independent investigation and effective monitoring of the quality of VA health care and appropriate corrective actions thereafter.

The Committee would greatly appreciate receiving your comments regarding these measures. Please make every effort to respond by July 14, 1987.

With warm regards,

Cordially,

Alan Cranston
Chairman

Enclosures

cc: Honorable Frank H. Murkowski

Identical letters sent to:
Mr. Phil Riggin, The American Legion
Mr. Robert O. Muller, Vietnam Veterans of America
Mr. Richard W. Johnson, Jr., Non-Commissioned Officers Association of the USA
Mr. James N. Magill, Veterans of Foreign Wars of the United States
Mr. John F. Heilman, Disabled American Veterans
Mr. Doug Vollmer, Paralyzed Veterans of America

AMVETS
National Headquarters
4647 Forbes Boulevard, Lanham, Maryland 20706
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NATIONAL LEGISLATIVE DIRECTOR

20 July 1987

Senator Alan Cranston, Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Mr. Chairman:

In reply to your letter of 6 July 1987, AMVETS is pleased to join with the distinguished bipartisan leadership of the Senate, under your inspiration, in enthusiatically supporting enactment of S.1464, the Veterans' Beneficiary Travel Reimbursement Restoration Act of 1987. Efforts of the VA, in conjunction with promulgation of the Administration's FY 1988 budget, to, in effect, preclude hundreds of thousands of veterans from realization of their earned entitlement to medical care by preventing them from traveling to VA hospitals, is a distortion of our national priorities which the proposed legislation is designed to rectify. We are pleased to note that H.R.2327, with a similar purpose, has passed the House of Representatives on 30 June 1987.

You also requested our views on S.1443 and S.1444, bills to establish an Office of Medical Inspector General and an office of Assistant Chief Medical Director for Quality Assurance. AMVETS fully appreciates the concern for vigilant quality assurance in the VA medical system. We believe, however, that that objective is more readily realized by placing investigative responsibility in the hands of capable people under a system which channels responsibility as directly as possible to the Administrator of Veterans Affairs, rather than by creation of two new and expensive "autonomous" bureaucracies, whose primary function would be to engage in jurisdictional contests with each other and the VA Inspector General and file voluminous periodic reports to the Congress. We need a system which clearly identifies responsibility; not one which obscures it so that when and if fault need be found, no one knows where to look for it.

The limited budgetary resources of the VA should be committed to delivering service to veterans rather than creation of more high paying jobs at the central office.

Sincerely,

DAVID PASSAMANECK
Lt. Col. USA, Ret.
National Legislative Director

DP/ljh

BLINDED VETERANS ASSOCIATION
1726 M STREET, NORTHWEST, SUITE 800 • WASHINGTON, D C 20036 (202) 223-3066

July 21, 1987

The Honorable Alan Cranston
Senate Hart Office Building 112
Washington, DC 20510

Dear Senator Cranston:

In response to your letter of July 8, 1987 requesting our comments on S.1443 S.1444 and S.1464, we want to express our appreciation for the opportunity to share with you our position on these vitally important pieces of legislation. You acknowledged in your letter having received our letter supporting S.1234 on Beneficiary Travel introduced by Senator Chafee. This legislation is the companion to H.R.2327, which has already passed overwhelmingly in the full House (420-1).

After careful review of S.1464, the BVA continues to support S.1234 primarily because under the Chafee bill there is no deductible. We are deeply concerned that the implementation of a deductible into any beneficiary Travel Program will serve as a means to deny health care to eligible veterans who will be unable to access the VA health care system. As you know, the BVA was outraged when the VA virtually eliminated the Beneficiary Travel Program with the implementation of their new regulations on April 13, 1987. We were in the forefront of opposition from the moment they announced proposed changes in the regulations last fall. We also recognize the need for committed efforts at deficit reduction, but do not feel a program of such vital importance to the ealth care of our nation's veterans is the way to go about reducing the deficit.

The vast majority of veterans utilizing the VA health care system live within a 35 mile radius of VA facilities and therefore, under S.1464, would not receive reimbursement for their travel expenses. In many cases, this would serve to deny them access to those facilities. This would be especially true of severely disabled veterans unable to use public transportation, if available. This would also apply to elderly veterans who tend to have more limited incomes and who are also multiply disabled and in greater need of regular health care. Additionally, prior to the implementation of the new regulations, the VA provided transportation (station, car, or hired cab) for a number of the latter who had no other means of getting to VA facilities. It appears that S.1464 would not restore that necessary policy.

Although there may be some veterans who are able to defray the expense of travel to and from VA health care facilities, it would be an administrative nightmare to try and sort out those who can and cannot absorb that expense. We are also concerned about the possible administrative cost for the VA that would be incurred if a deductible were implemented.

The BVA also is concerned about those veterans whose annual income may be above the pension limit and therefore excluded from the Beneficiary Travel program. Specifically, the cost of travel to Regional Specialized Medical Programs such as Blind Rehabilitation Centers and Clinics may serve as a deterrent to those

Beneficiary Travel be paid for any veteran whose rehabilitation needs can only be met by VA regional Specialized Medical Programs.

Finally, we are concerned about the provision in S.1464, which would in effect legalize the practice of local VA medical care facilities of paying less than authorized levels of beneficiary travel. Granted the provision would require those facilities to apply for and receive a waiver or deviation for such practices, but we are concerned about the monitoring of such waivers. Apparently a significant number of facilities have engaged in this practice with VACO having no knowledge of such practices. It is very difficult for veterans at the local level to know if practices are within regulations or not and have to rely on local VA officials for truthful interpretation of regulations. If a local facility needs travel funds to support other medical care programs, this problem should be made known to VACO officials so that adjustments can be made in allocations for medical care. The waiver may serve as a means for local management to conceal the fact they are not efficiently managing the remainder of their health care account and have to borrow from travel funds. Certainly, if it can be established that a facility has no need for travel funds, they should be applied to other health care programs. We feel this would be highly unlikely, however.

The BVA has long supported the concept and indeed the delivery of quality health care to our nation's veterans. Quality care has always been a top priority in any recommendation made by BVA with respect to programs affecting blinded veterans and should be the top priority of the free world's largest health care delivery system. However, by virtue of being the largest health care system and the fact that it is operated by the Federal Government, it receives much closer scrutiny from the general public. As a result, every flaw that is discovered in the system lends itself to being blown out of proportion and only horror stories are reported. We do not feel this kind of atmosphere is conducive to appropriate legislation for resolving identified problems. In our opinion, policies developed in reaction to public criticism are reactionary at best and may result in programs that are overkill.

Although we support S.1443 legislation to establish an office of Medical Inspector General within the office of the CMD, we are concerned that it may be an over-reaction. It seems clear the existing staff in the Medical Inspector's Office may be inadequate to monitor patient incidents within VA medical care facilities. We wonder if that staff needs to be expanded to the extent called for in S.1443.

Similarly, we question the need for such a dramatic increase in personnel in the IG's office as required by S.1444. It appears that the concept of an Assistant Inspector General for Health Care Quality Assurance Review is a good one. We question the timeliness of such enabling legislation. It has only been two years since the VA Quality Assurance program has been initiated. Is that sufficient time for the program to be in place with bugs worked out before additional corrective legislation is undertaken?

Let there be no mistake, the BVA supports both pieces of legislation calling for accurate reporting and monitoring of patient incidents and assuring quality health care delivery. We only want to insure this is accomplished in the most reasonable fashion dictated by sound management practices not over-reaction to unfavorable publicity in the media.

Once again, the BVA wants to express its appreciation for the opportunity to present its views on these important pieces of legislation affecting our nation's veterans. VA health care should not only be second to none, and of the highest quality, but also accessible to all veterans who are either entitled or eligible for such care. Our nation's veterans have earned no less. As always, the BVA stands ready to work with the committees of Congress on these or any other bills affecting veterans.

Very Sincerely,

Robert Routh, Jr.
National President

NATIONAL CAPITAL OFFICE
NCOA
225 North Washington Street • Alexandria, Virginia 22314 • (703) 549-0311

July 14, 1987

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
414 Russell Senate Office Building
Washington, D.C. 20510-6375

Dear Mr. Chairman:

Thank you for inviting NCOA's comments on legislation creating a Medical Inspector General (S.1443) and an Assistant Inspector General for Health Care Quality Assurance Review (S.1444) within the Veterans Administration. NCOA is pleased to endorse these proposals.

The combined effect of adopting these two measures will provide the VA's Department of Medicine and Surgery (DM&S) an opportunity and the resources to police its own conduct and performance while concurrently providing the agency's Inspector General the resources and expertise to review DM&S actions. It is important to NCOA that these measures be adopted concurrently. Adoption of only one measure would, in our opinion, be imbalanced. Accordingly, NCOA recommends that the provisions of S.1443 and S.1444 be combined into a single initiative. At the same time NCOA recommends the legislation be modified to provide new hiring authority and additional funding to support the activities proposed in the legislation. NCOA has sincere reservations about staffing and funding these efforts from a system which has been essentially frozen for the past three years.

NCOA is also pleased to endorse legislation regarding the beneficiary travel program. S.1464 would reinstate the program which was terminated by administrative action earlier this year. However, the bill provides substantial latitude to the Administration in paying those benefits. The House bill on the other hand recreates beneficiary travel as an entitlement program which gives the VA much less latitude in its administration. This approach is likely to be somewhat more expensive (by estimate about $3 million) than S.1464. However, it is also likely to be more reliable in meeting the needs of veterans. Inasmuch as NCOA has already conveyed to the House its support for the House bill and since the additional cost seems a nominal price to pay for the advantages of the bill, NCOA encourages the committee to adopt the House approach to resolving the problem.

Honorable Alan Cranston
July 14, 1987
Page 2

Thank you again for this opportunity to comment on these important measures.

Sincerely,

Dick

Richard W. Johnson
Director of Legislative Affairs

RWJ/car

cc: Honorable Frank Murkowski

PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947–1987

July 17, 1987

The Honorable Alan K. Cranston
Chairman, Committee on Veterans' Affairs
414 Senate Russell Office Building
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

I am in receipt of your letter dated July 6, 1987, requesting comments pertaining to your recent introduction of certain legislation. We are in agreement that the legislation addresses two major issues currently facing the Veterans Administration: beneficiary travel reimbursement and quality assurance.

On behalf of the members of PVA I appreciate of the efforts of yourself, and Senator Frank Murkowski, the cosponsors, and staff for these bipartisan initiatives S. 1464, the "Veteran's Administration Beneficiary Travel Restoration Act of 1987," S. 1443, "Veteran's Administration Assistant Inspector General for Health Care Quality Assurance Review Act of 1987," and S. 1444, the "Veteran's Administration Medical Inspector General Act of 1987."

After careful review of S. 1464, we are greatly concerned with certain provisions of the bill. We do not oppose the basic premise of establishing triggers to eliminate payment of minimal travel costs, but we do find other aspects of the bill untenable. Specifically:

°We are opposed to provision SEC. 2., Section 111 (b)(i) which can be construed as providing the Administrator the authority to elect not to make any beneficiary travel payments whatsoever.

°Section 111 (2)(A)(B)(C) undoubtedly would require records keeping for the stipulated payment schedules. PVA believes this will create an added, excessive administrative burden on VAMC staff. The potential for possible overpayments of Beneficiary Travel may occur, also which will result in the need for additional administrative burden for overpayment recoupment. This additional record keeping process is cumbersome and costly, considering it must be accomplished monthly.

The Honorable Alan K. Cranston
July 17, 1987
Page 2

°We are opposed to Sections 111 (2)(B)(i) and (2)(B)(ii) to provide medical facilities independent authority to deny beneficiary travel on a basis apart from established regulations. This would cause inconsistencies in program payments, i.e. contingent on the VAMC budget condition. If under these circumstances a facility is experiencing a shortfall in operating funds, or those funds are not being managed effectively then a VAMC is not managed effectively, beneficiary travel can be arbitrarily eliminated or reduced using the reason that the funds are necessary for care and service.

°Section 111 (2)(h)(i) in essence provides justification to reduce payments where voluntary services have been recently established to replace existing beneficiary travel authorization. It should be realized that not all veterans' organizations have the resources to participate in a program where "The Administrator, in consultation and coordination with the Secretary of Transportation and appropriate representatives of veterans' service organizations, shall take all appropriate steps to facilitate the establishment and maintenance of a program under which such organizations or individuals who are volunteering their services to the Veterans Administration would take responsibility for the transportation..."

°Section 111 (2)(h)(i) will provide communications with the Secretary of Transportation for the purposes of coordinating transportation services. Local public accessible mass transportation or paratransit services are not always available in all localities where VAMC's are located. Additionally, transit operations, schedules, mandatory 48 hour notice for transportation appointments, and priorities for services, all contribute to the unreliability of this source of expected support.

PVA is opposed to S. 1464.

PVA supports S. 1443 and S. 1444 collectively. These measures will establish the Office of Medical Inspector General and an Assistant Inspector General for Health Care Quality Assurance Review in the Office of the Chief Medical Director of the Veterans Administration. Together these efforts will ensure that the credibility and quality assurance is maintained and enhanced for VA health-care programs provided to our nation's veterans.

The only concern PVA might express over the enactment of the legislation would center on the cost of implementation. The enforcement of adequate quality assurance standards and procedures in any health care delivery system is an admirable and necessary goal. However, the process can require procedures which are not without certain open and hidden administrative costs at all levels of the system. According to the legislation, the funding to support and staff the Office of the Medical Inspector General are to be obtained from funds other than those appropriated to support the central office operation of the Department of Medicine and Surgery. In other words, these funds, as well as other costs associated with the maintenance and operation of the Medical Inspector General's Office, are to be derived from existing funding currently directed to the on-going provision of health care services within the VA system. PVA believes, in light of the current strain on overall VA resources and the definite need to implement an adequate quality assurance program, that the Committee include within the legislation a mechanism which can clearly identify the true cost of implementation of this activity over a period of time in order to assess whether additional appropriations are required to support the quality assurance process.

We appreciate your request for our comments, and thank you for your concern and interest to introduce these measures. If we can be of further assistance, please do not hesitate to contact us.

Sincerely yours,

Douglas K. Vollmer

Douglas K. Vollmer
National Legislative Director

DKV:cg

c.c. The Honorable Frank H. Murkowski

The American Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

July 17, 1987

Honorable Alan Cranston, Chairman
Senate Veterans' Affairs Committee
SR-414 Russell Senate Office Building
Washington, DC 20510-6375

Dear Chairman Cranston:

This will respond to your July 6 inquiry as to the views of The American Legion concerning legislation, S. 1464, to restore eligibility for beneficiary travel allowances and legislation, S. 1443, the Veterans Administration Medical Inspector General Act of 1987. I have asked the Deputy Director of our National Veterans Affairs and Rehabilitation Commission to review the legislation and his memorandum to me on the subject is enclosed for your review.

Before closing we wish to add that our response might have been more comprehensive had we received your inquiry prior to July 14. As always, your attention to the views of The American Legion is appreciated.

Sincerely,

Paul S. Egan, Deputy Director
National Legislative Commission

THE AMERICAN LEGION
1608 K STREET, N.W.
WASHINGTON, D. C. 20006

Memorandum to: Paul Egan **DATE** July 17, 1987

This is in response to your request that we comment on the legislation described in the letter from Senator Alan Cranston to Phil Riggin dated July 6, which we received on July 15.

S. 1464 would restore eligibility for beneficiary travel to some of the veterans who are no longer entitled as a result of the regulations implemented by the VA on April 13, 1987.

Our position is that the beneficiary travel program should be restored fully as it was set forth in 38 CFR 17.100 prior to the April 13 amendment of the regulations. We support cost containment in the beneficiary travel account through more careful management of the program.

However, obviously, if we were given a choice between taking the program as it is, as opposed to what is set forth in S. 1464, we would choose the latter.

S. 1443 proposes the establishment of an office of the Medical Inspector General, that would be directly accountable to the Chief Medical Director, and the establishment of an Assistant Chief Medical Director for Quality Assurance.

Additionally, S. 1444 - described as a complimentary bill, would established the position of Assistant Inspector General for Health Care Quality Assurance Review in the VA's Office of Inspector General.

Based upon the recent GAO Report entitled "VA's Patient Injury Control Program Not Effective" (GAO-HRD-87-49), and the report of the Committee on Government Operations on "Patients at Risk: A Study of Deficiencies in the VA Medical Quality Assurance Program", there is a definite need for some action to be taken.

S. 1443 would set forth a situation where the Medical Inspector General would report to the Chief Medical Director. However, according to the introductory language, the legislation would also provide for the autonomy of the MIG by authorizing that office to carry out investigations deemed necessary by the MIG, without obtaining prior approval from either the CMD or the Administrator.

There is a question as to the objectivity of the Medical Inspectors office within its present staff alignment. In addition, the office is grossly understaffed to fulfill its function. This bill would mandate the Administrator to transfer to the MIG - from funds other than those appropriated to support the Central Office operation of DM&S - the full-time equivalent employees and funds to support 10 MIG positions. This would certainly help alleviate the current staffing problems.

In addition, the MIG could not be assigned any operational responsibility for quality assurance or risk management activities, including patient injury reporting for which this office is currently responsible.

Upon preliminary review of this legislation, we can support its intent, in principle. However, we reserve the right to comment further on specific points of the bills following closer scrutinization.

John F. Sommer, Jr.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

July 19, 1987

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for the opportunity to comment on two bills currently before the Senate Veterans' Affairs Committee.

The current position of the Veterans of Foreign Wars on beneficiary travel as mandated by Resolution No. 617 calls upon Congress to restore a minimum funding level of $100 million for the beneficiary travel account. As the VFW opposed the recent mileage deduction implemented by the Veterans Administration for beneficiary travel, we cannot support the monetary deduction as provided in S. 1464. The VFW appreciates the concern of the Chairman and Ranking Minority Member of the Senate Veterans' Affairs Committee in your attempt to rectify the current unacceptable beneficiary travel regulations and we look forward to working with the Committee in arriving at a mutually acceptable solution.

In your letter, we were also asked to comment on S. 1443, the "Veterans Administration Medical Inspector General Act of 1987." As you know, the VA currently has in place the Office of Quality Assurance and the Office of Medical Inspector--both serving in a "watchdog" capacity within the Department of Medicine and Surgery. While the VFW has on occasion in the past been critical of the Office of Medical Inspector, we believe the problems that exist can be rectified. Of major concern is the current lack of adequate staffing in the Office of the Medical Inspector. Additional funding to provide increased staff will, in our opinion, enhance the capability of the office to properly implement its mandated role. We also believe the Medical Inspector should have greater latitude to contract for top quality renowned, unbiased medical experts to assist the Office in specific situations. While the Medical Inspector does have this authority, it should be expanded and utilized.

The Honorable Alan Cranston
July 19, 1987
Page 2

With respect to the Office of Quality Assurance, we also believe improvements must be made. One must keep in mind, though, this office is relatively new and should be given time to prove its worth.

For these reasons, the VFW believes, for the time being, the VA should turn its attention and resources to improving its present capabilities rather than creating another position.

Sincerely,

James N. Magill
JAMES N. MAGILL, Director
National Legislative Service

JNM/slw
cc: The Hon. Frank H. Murkowski
Ranking Minority Member, SVAC

STATEMENT OF THE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Submitted To The

Committee On Veterans Affairs
United States Senate

On

S.1195, The Veteran's Administration Health-Care
Personnel Act of 1987

Mr. Chairman:

The American Occupational Therapy Association (AOTA) appreciates the opportunity to provide the Committee with testimony concerning S.1195, the Veterans' Administration Health-Care Personnel Act of 1987.

Our Association represents over 44,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy is a health profession which has its foundation in the medical management of patients. The service is provided to persons of all ages who are physically, psychologically, or developmentally disabled. It involves the functional evaluation and treatment of patients with diagnoses such as stroke, heart attack, arthritis, diabetes, burns, spinal cord injuries, alcohol and drug abuse, and psychiatric disorders. The purpose of occupational therapy is to direct those patients to achieve a maximum level of independent living by developing those capacities which remain after disease or illness. Approximately 700 occupational therapists work in the Veterans Administration medical system. Occupational therapists in the Veterans Administration are frequently involved in programs such as acute psychiatric care, geriatrics, cardiac rehabilitation, alcohol and drug rehabilitation, and programs to teach the physically handicapped independence in activities of daily living which may include feeding, dressing, and mobility. Occupational therapists function as members of the rehabilitation team.

For several years the Association has been deeply concerned about problems relating to the recruitment and retention of qualified occupational therapy personnel in the Veterans Administration.

Historically, many occupational therapists were attracted to the Veterans Administration due to a diversity of patients and programs, competitive salaries, good benefits, and continuing education opportunities. Over the past years, however, our members have reported that the system has not allowed the growth in occupational therapy in areas such as program development and upward mobility of staff with advanced education. In addition, salaries and many of the benefits have fallen behind the private sector. Based upon information from our members working in the system, staff morale and the scope and quality of occupational therapy services available to veteran patients has been adversely affected as a result.

The 1986 survey of health occupations staff conducted by the Veterans Administration Office of Personnel and Labor Relations provides persuasive data about many of these problems. According to the survey, over 40% of the Veterans Administration medical facilities surveyed reported difficulty recruiting and retaining occupational therapists. Occupational therapy has the second highest vacancy and turnover rates of any health profession in the Veterans Administration. The reported turnover rate for occupational therapists is 23%, with a system-wide vacancy rate approaching ten percent. Over 60% of the survey respondents noted that occupational therapists working in local non-Federal medical facilities receive salaries which are higher than their Veterans Administration counterparts performing comparable work, and some 63% of facilities reported that tuition assistance provided by private-sector facilities to their employees placed the Veterans Administration at a competitive disadvantage.

Additional information developed by this Association and previously provided to the Committee (March 19, 1987, letter to Chairman Cranston) highlights the fact that in many categories the situation has deteriorated further since the Veterans Administration survey was conducted, and that resulting staff shortages, vacancies, and program closures have affected quality of patient care.

The Association conducted a survey of occupational therapy departments throughout the Veterans Administration medical system during the period of March 6 - 11, 1987. The responses from 142 facilities indicated that:

- 15% of existing occupational therapy positions in the Veterans Administration medical system are currently vacant. These vacant positions have remained unfilled for, on average 10.9 months, and many have remained vacant for well over one year.
- A total of 70 facilities (approximately 50% of those responding) have closed 145 specific programs within their occupational therapy departments because of staffing shortages. A number of facilities reported a scaling-back of occupational therapy programs for the same reasons.

- To adequately staff existing programs a total of 960 full time occupational therapy positions are needed systemwide. This reflects the need for a 23% increase in currently authorized full-time equivalent occupational therapy positions. When existing vacancies are taken into account, a shortfall of 35% exists in occupational therapy personnel in the Veterans Administration medical system.

- A total of 113 facilities, or almost 80% of those responding, provided information indicating that quality of patient care has been adversely affected because of occupational therapy staffing shortages.

- Systemwide, facilities reported that 17% of existing occupational therapy staff are planning to leave the Veterans Administration within the coming year.

Additional survey comments as well as information supplied by our members in the Veterans Administration cite a lack of educational assistance, both at the undergraduate and graduate level, as a further impediment to the recruitment and retention of qualified occupational therapy personnel.

The Association strongly supports the initiatives contained in S.1195, and applauds the Committee for considering and addressing these difficult problems.

Three specific components of S.1195 would, we believe, be of substantial assistance in addressing the pervasive recruitment and retention problems among occupational therapy personnel in the Veterans Administration. Section 2 of the legislation would allow the VA to hire and pay occupational therapist under the Title 38 personnel system. Other matters of employment such as hours of duty, performance appraisals, leave, and other matters would remain governed by Title 5, U.S.C. It is our view that moving occupational therapists into this "hybrid" Title 38/Title 5 category would be a major step forward in providing the Veterans Administration with the tools and necessary flexibility in appointment and pay matters related to occupational therapy staff, provided that the agency aggressively implements this new authority envisioned in S.1195.

We note that the Veterans Administration opposes this provision, based upon their view that its prior application to other professions, as authorized in Public Law 98-160, did not significantly enhance recruitment and retention. The agency further states that the only practical result of enactment of the provision would be to reduce the time required to process special rate requests by six to eight weeks through eliminating Office of Personnel Management (OPM) review. It is our understanding that conversion to the "hybrid" Title 38/Title 5 system has proved beneficial in many respects for those professions affected by P.L. 98-160. Further, any mechanism that serves to reduce the time required to process special rate requests can only serve to improve the existing process. Special salary rates for occupational therapists under existing authority have been requested by very few facilities precisely because of the inordinate amount of time required for approval, in some cases ranging up to several months.

In many instances prospective candidates for employment have, in the interim, found alternative employment elsewhere.

Section 5 of the legislation would establish a Health Professionals Educational Assistance Program. As part of this program, S.1195 would provide the VA with more flexibility to grant scholarships by extending eligibility for this assistance to all individuals accepted, or enrolled, as students in a health-care program determined to be needed by the agency. Existing law restricts the awarding of scholarships under this program to those categories of health-care providers that are under the Title 38 personnel system. Opening this program to other individuals who will provide direct patient-care services, such as occupational therapy students, will provide an important tool to assist the Veterans Administration in attracting quality professionals in areas of acute shortage. This component of the bill would also increase the period of obligated service for scholarship participants from one to two years for each year the student received a scholarship. The Association strongly supports the concept of obligated service. We believe that tax-supported training efforts should yield direct benefits for the public, and a service obligation is an equitable method to achieve that goal. However, we do have reservations about increasing the obligation ratio to two years for every year of scholarship assistance, to the extent that it might deter potential applicants.

Section 5 of S.1195 would also establish a new tuition reimbursement program to provide financial assistance for full-time VA health-care personnel for academic courses leading toward completion of any degree program in their field if it is determined that it would help alleviate recruitment and retention problems. An employee who has worked full-time for the agency for at least two years could receive tuition reimbursement up to a maximum of $2,000 per year. The individual would be required to work for the VA for one year following their completion of the degree or the last course taken. To be eligible an employee would have to be involved in providing direct patient-care service, or services incident to direct patient-care. We believe the capability to offer tuition assistance for the specific purpose of obtaining a degree is a substantial improvement over existing statutory authority available to the VA, and that this provision will help restore a competitive balance between the agency and many private sector health-care facilities.

In summary, the American Occupational Therapy Association believes that S.1195, if enacted, could prove to be of substantial assistance to the Veterans Administration in addressing recruitment and retention problems among occupational therapy personnel. We urge the Committee to act expeditiously on the proposal, and we stand ready to provide any assistance necessary to assure the provision of quality occupational therapy services to our nation's veterans.

Statement of the
American Optometric Association

On

Recruitment and Retention of
Veterans Administration Optometrists

Submitted to the

COMMITTEE ON
VETERANS' AFFAIRS

UNITED STATES SENATE

May 21, 1987

INTRODUCTION

The American Optometric Association is a professional society representing some 25,000 doctors of optometry, optometry residents, optometry students and educators across the nation. As an organization devoted to improving the vision care and health of the public, the American Optometric Association promotes the art and science of optometry wherever it is practiced.

A Doctor of Optometry is a health care professional who is specifically educated and licensed in each state to examine, diagnose and treat conditions of the vision system. Optometrists examine the eyes and related structures to determine the presence of vision problems, eye disease and other abnormalities. Through advanced technology and clinical training, optometrists may detect diabetes, hypertension, arteriosclerosis and other diseases of the body as well as primary ocular conditions such as glaucoma and cataract, which require referral to other health care practitioners for treatment.

I.

VETERANS' ADMINISTRATION AND VETERANS' NEEDS RE: OPTOMETRIC SERVICES

With the signing of Public Law 94-581 (1976), the enabling legislation which created the VA's Optometric Service, the Veterans Administration commenced recruiting qualified doctors of optometry to begin to meet the significant demand for eye care of the veteran population. Prior to the 1976 legislation the Congress reported that two-thirds of all screened veterans required eye care, yet fewer than one in ten eligible veterans received this needed eye care because there were virtually no VA staff optometrists or teaching affiliation programs. PL 94-581 enabled the VA to recruit 100 optometrists (as a start), created educational opportunities for optometry interns and residents and offered more competitive salaries (via the Title 38 pay system). These improvements were judged necessary by the Congress to modernize the VA's outdated practice of using only eye surgeons to provide surgical and nonsurgical care as well as primary eye care. The VA had been unique in its failure to use optometry staff, since the military and PHS hospitals as well as private HMOs and other groups generally employed two to three staff optometrists for each eye surgeon (ophthalmologist). Among the general civilian practices, there are twice as many optometrists (approximately 25,000) as ophthalmologists (approximately 13,000).

Prior to PL 94-581 the VA had only eight staff optometrists and one teaching program. Unlike all other federal hospital systems, the VA was forced to use eye surgeons to render not only eye surgery but also all levels of eye care, down to routine non-emergency screenings. This was noted by Congress to be a poor use of manpower and not cost-effective since there was only about one optometrist for every twenty ophthalmology staff and resident, a ratio far out of agreement with any rational distribution of medical specialties, forcing the VA to either provide primary and basic eye care so that VA surgeons would be free to perform their specialty or, inappropriately, reducing their ability to provide surgical care in an effort to provide general and primary care. This was not cost-effective since studies indicate well over half of all veterans seeking eye care can be fully cared for by optometry staff. Further, this more rational profile would also enhance ophthalmology care and ophthalmology training programs. This could result since, with optometry providing primary care and referral for surgery, ophthalmologists would have more time to practice their specialty and have more surgical referrals to them thereby making the best use of this scarce medical resource. In other words, the Congress announced to the VA in 1976 that the agency was out of date with all other federal and civilian providers of comprehensive eye care by relying solely on eye surgeons rather than a team of specialists, so that each specialty is appropriately employed. It simply didn't make sense to the Congress that the VA should be forced to use eye surgeons or eye surgeons in training to take time from providing their special care to also provide primary and general eye care which could be provided at less expense by optometry staff.

These management and cost concerns were further elaborated by the Government Accounting Office when it studied the VA's implementation of PL 94-581 (Study, The Role and Use of Optometry in the Veterans Administration Needs Improvement, GAO, June 21, 1978). The GAO also cited the inappropriate use of eye care manpower by the VA as well as the general failure to implement PL 94-581. The GAO called for the employment of at least 200 full-time optometrists and the creation of significant numbers of optometry teaching affiliations as well as the strengthening of the Service Director's office in VACO. The GAO also noted that in all other systems rendering eye care there were more optometrists than eye surgeons, yet the VA continued to be unique in having a reverse staffing ratio.

In its reply to the GAO study, the VA acknowledged the optometry staffing shortage and stated that it was hiring, as a first step, 30 full-time optometrists and would, over a multi-year period, hire the 100 additional staff called for by the Congress, producing a total force of some 100 full-time optometrists. The VA also stated to the GAO that this was a first step, and it agreed with GAO that approximately 200 full-time optometrists were needed in all. The VA also agreed that it had not yet created significant numbers of teaching affiliations and these would also be implemented.

Further evidence of the optometry staff shortfall was shown by an estimate prepared by the Director, Optometric Service in 1980 that 296 full-time staff were needed. The Director also cited the 1980 HHS health manpower requirements that, when applied to the VA's staffing and veteran population, it classified veterans as being in an "Underserved" category. Using HHS methodology, 132 full-time optometrists would be needed to marginally bring the VA population out of the category of "Underserved". This HHS formula took into account both ophthalmology and optometry staff. As a result of these and other portrayals, the VA Chief Medical Director, in 1980, publically acknowledged a minimum of 120 full-time optometrists were needed.

Again in 1982, the Congress queried the VA as to where it stood in modernizing its eye care by securing appropriate numbers of staff optometrists. First initiated by a letter from Senator Thurmond for detailed information on the development of the optometry program, this request was broadened in scope by Congressman Montgomery to include not only all eye clinics but both optometry and ophthalmology manpower, their working relations, the impact upon eye care (quantity and quality) by optometrists, and the opinions of the hospital chiefs of staff on the effects produced by the use of optometry staff. This inquiry by Senator Thurmond and then by Congressman Montgomery was first triggered by a concern that the VA had still, some seven years since the passage of PL 94-581, only added about 55 of the 100 optometrists intended by Congress via PL 94-581.

The VA conducted a survey in order to answer the congressional inquiries. This 1983 survey, conducted and jointly prepared by the VA's Surgical Service and Optometric Service, was endorsed by the VA's Department of Medicine and Surgery and transmitted to Congress in April, 1983 as the agency's response to the issues raised by the congressional inquiries.

The survey reported data from 168 of the 172 VA medical centers and remains today, even four years after its release, the most comprehensive and exhaustive study to date. The study reported deficiencies and positive aspects of VA eye care; some of these are encapsulated below.

Deficiencies Cited By The Study:

- "The bulk of clinical staff is provided by ophthalmologists and residents in ophthalmology. Total ophthalmology staff is 372.2 FTEE (includes 235 residents) as compared to a total optometry staff of 92.3 FTEE (includes 26 residents). There are 0.25 optometry FTEE for every 1.0 ophthalmology FTEE. This ratio is low and is compared with other general health care systems (HMO, DOD, civilian) in Figure 3 where the range is from 2.5 to .9 optometry FTEE per ophthalmology FTEE." (Survey, Introduction, pg. 2).

- * Average waiting time for eye appointments was 38 days, with 84 centers in excess of 30 days and 73 centers having restricted acceptance of eye clinic appointments. (The ACMD for Professional Affairs determined any delay over 30 days to be unacceptable.) In fact, 41 medical centers had delays in excess of 60 days.

- * Twenty-eight stations had no eye clinic staff and 93 stations reported less than 0.1 FTEE optometry staff (less than 4 hours of optometry staff coverage per week).

- * There were 85 medical centers with ophthalmology teaching programs and only 41 with optometry teaching affiliations, with 235 ophthalmology residents being trained while only 26 optometry residents were in training.

Positive Study Findings:

Seventy-three medical centers reported having both optometry and ophthalmolgy staff and at these 73 stations which had initiated team eye delivery as envisioned by Congress via PL 94-581, their chiefs of staff reported that:

- At 56 centers, the chiefs of staff reported the professional cooperation between optometry and ophthalmology to be "excellent"; 15 reported "good" relationships; 2 reported "acceptable" and not one responded in the two remaining categories of "fair" or "poor".

- "All 73 (chiefs of staff) reported their optometry sections had increased the type, scope and quality of their station's eye/vision care." (Survey, Summary of Findings, pg 1).

- All 73 chiefs of staff reported that timely and appropriate referrals were being made by optometrists to ophthalmologists.

The VA report made a detailed station by station analysis of patient workload and staffing profiles, waiting times for eye appointments, and requests for resources. The report noted: "Based upon a review of each VAMC's response, its eye/vision needs, staff levels, affiliations, waiting times, and Rx activities, it was determined that 66 VAMC's needed increased optometry staff coverage and 26 needed increased ophthalmology staff coverage. These equate to 46 FTEE additional optometry staff and 9 FTEE additional ophthalmology staff."

Thus the 1983 Survey again confirmed that while the VA made some effort to implement a more rational cost-effective eye care delivery system, it had fallen far short. For example, the total full-time optometry staff in 1983 was 67 (70 as of 1987), far short of the 108 that would have resulted from adding the 100 called for by the Congress in 1976. Even the current 1987 figure of 70 full-time also falls far short of the 120 called for by the Chief Medical Director in 1980, the 132 required to meet the HHS criteria and the 200 agreed to by the VA in response to the GAO in 1978.

Additional Evidence Showing Cost-Effectiveness of the VA Optometry Staff

In addition to the above well-documented need for and desirability of optometry staff, further evidence has recently been revealed following the VA's adoption of DRG reimbursement methods in its Resource Allocation Methodology (RAM). The key feature of VA eye care delivery critized by all past studies has been the VA's inability to better tailor its eye care staffing to its patient care needs by primarily having only eye surgeons and their residents available. Thus, the VA was providing entry level, primary care as well as secondary and tertiary care using these tertiary care providers. As previously noted, such a staffing profile is not used by any other similar federal provider. This use of tertiary care providers resulted in a comparatively high cost-per-treatment episode since expensive and scarce eye surgeons had to be "all things to all people" under the antiquated VA system.

Even though the VA has fallen short of adding appropriate numbers of optometrists, there now exists a statistically significant number of jointly staffed team eye clinics with optometry and ophthalmology staff, residents and students. And for the first time within the VA, the RAM system has tracked the cost-to-benefit ratios of different patient care services within each hospital. These RAM-generated data support the opinion of Congress that greater use of optometry staff is cost-effective; the marginal cost-per-treatment episode has decreased dramatically with the introduction of optometry staff. That is, adding optometry staff to produce a more rational staffing profile greatly expands the number of patients who can be treated, reduces patient backlogs and greatly lowers the cost-per-patient treatment episode. Additionally, under the RAM cost accounting system, these team eye care clinics have become what is commonly referred to as "DRG gainers", generating resources for their VA hospital via the RAM methodology, far in excess of operating costs. The VA has documented what many other eye care provider models have maintained for years: optimum and least-costly eye care results when using a staff of optometrists and ophthalmologists in proportion to the need for their services (Appendix A).

To conclude this portion, all evidence to date indicates Congress was correct in creating an Optometric Service and calling for optometry staff and training programs as a means to improve VA patient care and lower cost-per-treatment episode. This is more important today than in 1976 due to the constantly shrinking federal dollar. However, the VA is unable or unwilling, even in the face of a preponderence of evidence from both outside and within the agency, to approach minimal staffing levels that it has publically acknowledged should be met. In view of severe budgetary problems facing the VA where each federal dollar must provide the maximum in cost effective patient care, coupled with a rapidly aging veteran population and its attendant increased eye care problems, the VA must now act to make the best use of its resources. With the ever-increasing numbers of eye care problems needing treatment in this expanding veteran population, the VA can ill-afford to defer meeting its self-acknowledged staffing needs; to do so would be both fiscally and medically inappropriate.

II.

THE EXISTING OPTOMETRY PROGRAM AT RISK

The above section dealt with the VA's failure to adequately recruit optometrists and develop the optometry program. This section addresses matters which are weakening the present optometry program so that, even in the face of proven excellent results, the VA is in danger of failing to preserve it. At the heart of this are the issues of recruitment and retention.

Non-Competitive VA Optometry Salaries

In 1976, PL 94-581 cited poor salaries as a central factor inhibiting the hiring of staff optometrists. By moving VA optometrists to the Title 38 pay structure, salaries were created which began to approach those in the private sector. While falling short of 1976 private practice incomes, these VA salaries were sufficiently competitive that high quality optometrists interested in hospital-based practice, as well as teaching affiliations, were successfully recruited. These individuals are now the senior clinic chiefs within the VA system and have developed both patient care, teaching and research programs, as a testiment to the quality of staff initially recruited. Unfortunately these VA optometrists' salaries have not kept up with increasing private sector incomes, particularly at mid and advanced career levels. The result is that increasing numbers of senior VA optometrists are leaving the system. These experienced VA clinicians are accepting leadership positions in other health care centers and teaching institutions. The salary gap is significant. The most recent data available show average full-time optometrists' salaries to be about $45,814 while the average privately practicing optometrists has a net income of about $62,673. This means the average VA salary is 36% below the average for the private sector. This salary gap is more critical because the VA optometrists are widely recognized to be of particularily high caliber in professional ability while having increased patient care responsibilities, due to training and the demands of a medical center environment.

The salary gap problem cascades down to the VA residency program as well, since all of these training programs are directed by these key senior optometry staff; with the absence of training program directors, the optometry residency program suffers.

In addition to the increasing retention problems, the VA, if it chose to recruit optometrists to complete the long-defered development of the optometry program, would face a serious recruitment problem. (Since the VA has failed to recruit the optometrists it said it needs to meet the congressional timetable, few positions are available and consequently recruitment is not even attempted.)

The effect of the salary gap is further compounded by the development of additional opportunities for practice in a medical environment, similar to the VA, so that the VA has lost some of its recruiting potential. The attributes of a team approach to eye care, emphasizing cost effectiveness as espoused by Congress in 1976, is to be seen in the private sector. In the past five years, there has been a rapid development of "co-management centers" whose key feature is team delivery care by optometrists and ophthalmologists. These centers now offer a medical environment attractive to recent optometry graduates. In the past few years, many VA residents have been recruited to these co-management centers following their VA training. In fact, many of these centers (and schools of optometry) require residency training (of which the VA provides the bulk) for appointment to the co-management center group. These attractive modes of practice, coupled with the expanding salary gap, have left the VA unable, in the main, to recruit its own residents, even though a prime reason for such residency programs is to recruit VA staff. Also, the co-management centers have recruited half of their clinic directors from the ranks of the senior VA optometrists. The problem can be distilled to the fact the VA, having established a standard of excellence for its staff training program, has allowed salaries to fall behind to such a degree that both its residents and senior staff are now rapidly being recruited away with the consequence that the investment the VA made in these programs is beginning to evaporate. It seems clear that another adjustment in salaries must be accomplished because the slippage since 1976 has produced salaries which are now about 36% below the average for private incomes. This salary adjustment is even more critical since the VA optometrists have exceptional demands made of them in their work environment. While we understand and appreciate the VA cannot be expected to fully match salaries offered by models and opportunities outside the VA, it should be expected that the agency could provide some monetary inducement as a signal that VA optometrists represent a highly valued resource. Such an indicator, when coupled with the admittedly professionally stimulating environment would allow the agency to retain these exceptional practitioners. But the VA cannot hope to retain these individuals with average salaries 36% below private practice. And the VA cannot hope to retain faculty caliber senior staff with salaries 36% below average salaries (see Appendix B). Finally, while the VA has admitted its optometry program is small (smaller than is required or anticipated by Congress), it has correctly prided itself on its quality of service. That quality is now showing the cracks of erosion and without some salary augmentation, the program is destined to erode to an unacceptable level. This erosion will spread and not only damage patient care but teaching affiliations as well, since the two are interrelated.

To conclude this portion, the VA Optometric Service and its teaching affiliations are of the highest quality. All available evidence proves the wisdom of Congress when, in 1976, it instructed the VA to modernize its eye care by building an Optometric Service. Increased numbers of patients are now being given higher quality and more comprehensive eye care at less cost-per-patient treated. Better use is being made of scarce eye surgeons, and reports from chiefs of staff unaminously agree that team delivery by optometrists and ophthalmologists is a quantum improvement; the VA's DRG system indicates increased productivity has resulted as well.

Unfortunately, in the face of ten years of consistent positive data, congressional urging and even its own studies, the VA has not honored its pledge to build its optometry program to even the lowest level recommended. That level was 108; the VA now employs 70 full-time optometrists. Since 1983 when the VA's own study cited an immediate need for 46 optometrists, it added just 6. This performance, viewed against a backdrop of the ever-increasing requirement to be more cost-effective and reduce cost-per-patient treated, falls short of adequate.

Finally, the VA is not acting to preserve the small but excellent program it has created. The salary gap can no longer be ignored. The VA must, through a program such as outlined below, begin to ameliorate this situation before the quality is damaged and the cost-per-patient is increased. In III, Recommendations, are what we offer as minimal steps to correct this problem. These measures are modest and require only small incremental costs. This program would only reduce the existing salary gap from 36% to about 30%, but it would provide important awards, not in a wholly monetary sense, but for recognition of important program responsibilites (see Appendix B, C).

III.

RECOMMENDATIONS

VA Optometry Staff

Depending upon the particular VA statement cited in the last six years, the minimal numbers of optometry staff range from about 110 to 120, with the GAO, AOA and other estimates upwards of 300. The AOA proposes the VA finally honor its long-standing commitment by meeting a staffing floor of about 110 optometrists. This would require the addition of 40 optometrists, which is close to the number cited in the VA's 1983 study. The AOA proposes this be accomplished over a three year period. By any standard this seems a fair request and one which would produce a staff level that Congress intended to be reached by 1981. Fiscal wisdom, evidenced by the VA's resource methodology, supports this position as the VA can no longer afford to misuse its medical specialists i.e., using eye surgeons to render optometric care.

Salary Gap

In addition to failing to meet congressional and agency committments on staff additions, the VA is now losing key senior clinicians to competing health care provider organizations. Because of this salary gap and the acknowledged quality of VA optometric services, the VA has now become a prime recruitment resource for these organizations. Therefore, some salary relief should be accorded these clinicians, just as salary relief has been given to other VA health care professions, due to the non-competitive nature of federal salaries for select health care disciplines. The cost for the proposed program is minimal, yet failure to provide this salary relief will accelerate the loss of experienced VA clinicians as well as teaching affiliations.

The American Optometric Association recommends that Congress ammend 38 USC 4118 to include optometrists. This salary augmentation should be limited to full-time staff. It should not be prorated for part-time staff who should receive no salary augmentation.

Salary enhancement should be distributed primarily to retain senior key staff; those individuals who have been, and continue to be recruited away from the VA.

* Full-time clinicians in grades Associate, Full and Intermediate with less than 6 years continuous service...$3,000 per annum.

* Full-time clinicians with more than 6 years continuous service holding grades Senior or Chief...$4,000 per annum.

- Full-time clinicians serving as the administrative chief of an optometry section, service or equivalent clinic...$2,000 per annum.
- Full-time clinicians serving as directors of a facility optometry training program for residents and/or interns...$2,000 per annum.

The estimated cost is under $300,000 representing less than 6% of the present optometry salary cost and will only reduce the salary gap of 36% to approximately 30% but will provide some recognition for additional program responsibilities.

We thank the Committee for the opportunity to offer our views and present the case for the VA's optometry program. We hope this testimony will assist the Committee in its deliberations on recruitment and retention problems of VA doctors of optometry.

APPENDIX A

VA Optometry and Resource Allocation Methodology (RAM)

In the VA, the RAM is composed of three elements: Diagnosis Related Groups (DRGs), Resource Utilization Groups (RUGs) and the Ambulatory Care Model (ACM). DRGs are codes attached to specific diagnoses that, when confined with length of stay data, determine the amount of compensation to the hospital for a medical or surgical admission. RUGs are units based upon the amount of skilled nursing care needed for long term patients. Finally, there is the ACM, where the majority of work performed by optometry fits in.

VA: A Team Approach to Eye Care

Prior to passage of PL 94-581, the VA used eye surgeons and residents in eye surgery to render virtually all of VA patients' eye care (there were only 8 full-time optometrists in the VA system before PL 94-581). This reality of ophthalmologist-only staffing meant that the VA was employing scarce and costly eye surgeons to provide the whole spectrum of eye care. In its accompanying language to PL 94-581, Congress noted that such an arrangement was neither cost-effective nor productive. The addition of staff optometrists to the program of eye care has produced a lowering of cost-per-treatment episode wherever optometry has been introduced. At VA medical centers where optometry has been incorporated, the ophthalmology productivity has been increased. That is, staff optometrists have been able to reduce the waiting logs, have identified more patients requiring surgical care and treatment for disease (referrals to other medical specialities) and have been able to refer more patients to ophthalmology, thus freeing ophthalmology from having to perform optometric procedures and allowing these eye surgeons to practice at their highest level of training. In this way, using a team approach to eye care, the optometrist and ophthalmologist (including residents in each speciality) are working at their highest levels of skills and training with the results that the cost-per-treatment episode has gone down. Congress was correct when it predicted economies when optometry was added to the mix of health care personnel in the VA medical system.

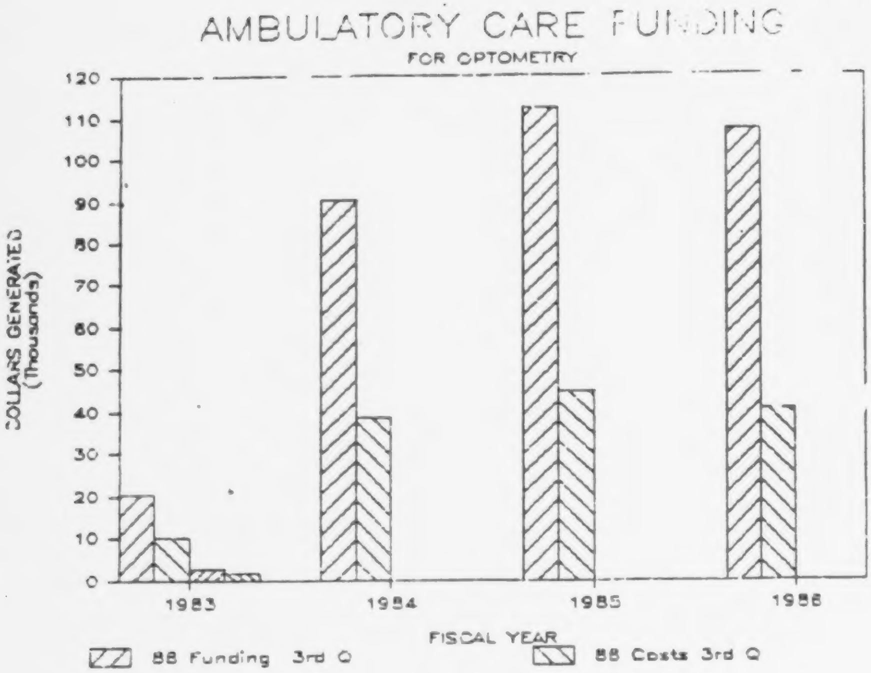
VA Optometry: A DRG "Gainer"

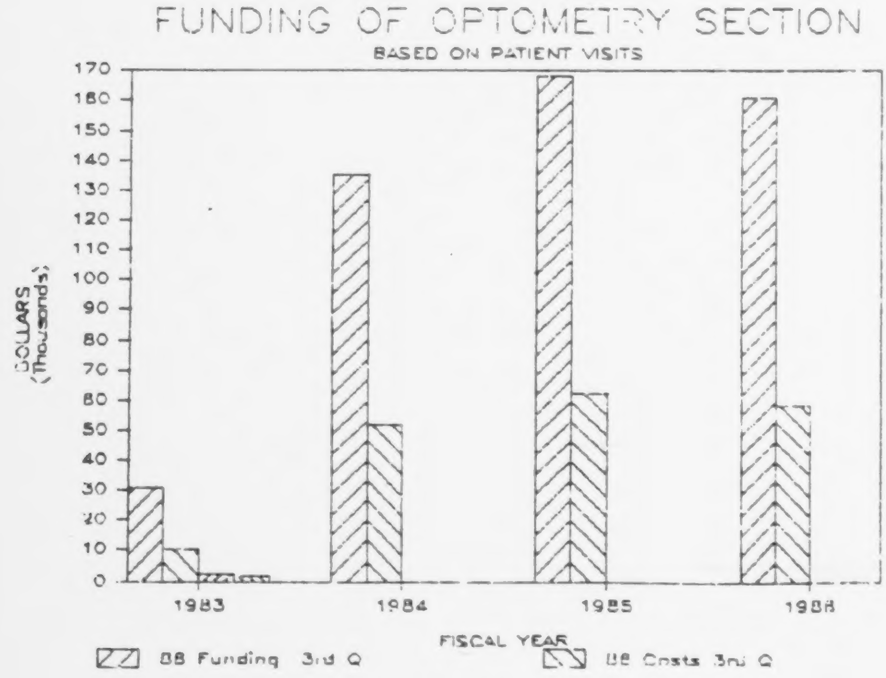
It is noted above that Congress predicted increased cost-effectiveness would result with the development of an optometry program in the VA. There is now evidence to support this prediction by the Congress. In fact, there is evidence which demonstrates that when an optometry program is added to existing ophthalmology coverage, that eye care center will have increased DRG credits and will become a significant DRG "gainer". Additionally when an optometry program is initiated in a VA medical treatment facility, it will generate weighted work units (WWU) far in excess to the funding required to operate it.

Optometry is, by-and-large, an outpatient specialty, and it is within the confines of the Ambulatory Care Model (ACM) that VA optometry demonstrates its productivity in its purest form. For instance, at the Columbus, Ohio VA outpatient clinic, the optometry program reports work unit credits close to three times the amount of funds required to operate the optometry program.

In the case of optometry working in a hospital-based setting employing an ophthalmology and optometry team, the quality of care has risen, more patients are being treated and the cost per treatment has gone down; another example of a DRG "gainer".

Based upon any measuring standard used by the VA as well as all settings employing optometrists, the quality of care has gone up, more patient care has resulted and there is a substantial "gain" for the medical treatment facility (the DRG generated mechanism for funding).





DANVILLE VAMC

APPENDIX B

National Association of Veterans
Administration Optometrists
424 Beacon St.
Boston, MA 02115

May 18, 1987

Mr. David Danielson
1505 Prince Street, Suite 300
Alexandria, VA 22314

Dear Mr. Danielson:

In response to your inquiry of March 10th, our society has conducted a survey of its senior VA service chiefs from representative VA medical centers across the country. I have also spoken with members of the society's Commission on Residencies about their concerns.

The survey confirmed the growing impression during the last three years that serious problems have begun to surface relative to staff compensation and residency stipends.

After discussing these matters with our society's membership chairman, and upon reviewing our recent survey, we have determined that over 20 individuals representing about 30% of our staff have left the VA. The survey revealed that the primary reason for leaving was inadequate compensation. These individuals were senior career chiefs of services, many of whom started their career as VA residents. Their loss is indeed unfortunate as they were generally chiefs of services having responsibility for both teaching and patient care.

Frankly, we are losing our senior chiefs due to two factors: first, the growing non-competitive VA compensation; and second, the development of multidisciplinary practice environments similar to the VA.

Our senior VA staff are being actively recruited by these multidisciplinary practice associations and are being offered attractive compensation packages which are significantly greater than the VA can now offer. Many of those who have left the VA would have remained if compensation differences amounted to only 20-25% as they had loyalty to the VA; most had been VA-trained and had been with the VA for over five years, intending to make the VA a career. I think the VA could have retained these clinicians if the salary gap had not been as pronounced as it now is. As an example, some of our residents are now being offered initial salaries equal and sometimes greater than the current maximum paid to senior VA service chiefs. Personally, I have received several offers from private sector practices. Most of my colleagues have received similar offers as well.

Based upon the survey and discussions, I believe a 100% match with the private sector would not be required since our senior staff are career oriented, wishing to remain with the VA and continue to direct academic teaching programs. My recommendation would be to increase compensation with some type of special pay for senior optometrists by about 10-15% over the existing base salary. While this increase would still leave our senior service chiefs well below the private sector, it would narrow the gap between the VA and salaries at the schools and colleges of optometry.

The other concern which all service chiefs raised in our survey process was the problem with the residency programs. Time and again, my colleagues asked me why optometric residency stipends are so low--about one-half the level of medical and dental residents. I have also been questioned why VA residents in optometry are administered by a different set of rules when VA optometrists, by federal statute and VA policy, are governed by the identical pay, personnel and disciplinary policies as are VA medical and dental staff. For instance, residents in optometry, if they enter VA service after VA residency are not credited with a years' government service as are medical and dental residents. Additionally, VA residents in optometry are not eligible for the same medical, leave, and other fringe benefits that are available to medical and dental residents. Reports to me show the present low stipends are causing the better quality applicants to bypass VA training in favor of more realistic stipend levels and personnel policies offered by the private sector. The simple question posed is: Why should a graduate O.D. who would start as an Associate Grade with full Title 38 benefits give up these by becoming a VA resident, when other Title 38 colleagues in medicine and dentistry do not? As I mentioned before, our residents, besides losing fringe benefits, also receive stipends one-half the amount of those paid to first-year medical and dental residents who have the same length of training as our residents. This inherent unfairness in the manner in which the VA is administering its residency programs damages our ability to recruit the most desirable residents for optometry.

I hope this information will be of help to you in assessing the current status of the VA's Optometry Service.

Sincerely,

Clifford Scott

Clifford Scott, O.D.
President

APPENDIX C

Representative Sample of

Survey Letters

Group
Health
Associates

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John E. J. McSweeney, M.D.
President
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Vice President/Administrator
Barry C. Malinowski, M.D.
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ALLERGY
Thomas J. Fischer, M.D.

DERMATOLOGY
David L. Broomall, M.D.

FAMILY PRACTICE
Gregory L. Isaac, M.D.
Maralyn M. Itzkowitz, M.D.
Alyce Kennedy, M.D.
Linda M. Tracy, M.D.

INTERNAL MEDICINE
Bernard B. Bach, M.D.
Remo J. DiSalvo, M.D.
Melvin M. Firestone, M.D.
Paula D. Fletcher, M.D.
William E. Froschauer, Jr., M
Joseph F. Hamad, M.D.
Stephen C. Hamilton, M.D.
Robert J. Hellmann, M.D.
Richard B. Kallenberg, M.D.
Peter G. Ruehlman, M.D.
Robert C. Smith, M.D.
Endocrinology
Cheryle B. Webb, M.D.
Gastroenterology
Andrew B. Minkin, M.D.
Infectious Diseases
E. Huxley Miller Jr., M.D.

OBSTETRICS and
GYNECOLOGY
Hari N. Budev, M.D.
Marihelen Dooley, M.D.
Richard J. Fry, M.D.
Gary J. Kanter, M.D.
Warren L. Metherd, M.D.
Allen R. Shade, M.D.

OPTOMETRY
Richard S. Deutch, O.D.
Timothy W. O'Leary, O.D.

OTOLARYNGOLOGY
Robert J. Schrimpf, M.D.
Thomas M. Schrimpf, M.D.

PEDIATRICS
Janet A. Borcherding, M.D.
Gail B. Croall, M.D.
Nancy M. DeBlasis, M.D.
Truddie R. Edwards, M.D.
Deborah M. Jonas, M.D.
John S. Longcamp, M.D.
Barry C. Malinowski, M.D.
Janice M. McConville, M.D.
Gary J. Weisenberger, M.D.

PSYCHIATRY
Adult
Mark J. Barbara, M.D.
Child and Adult
Jennifer J. Johnson, M.D.

RADIOLOGY
Eli Rubenstein, M.D.
William Dickens, M.D.

SURGERY
George M. Kerlakian, M.D.

URGENT CARE
John L. Tollack, M.D.

April 2, 1987

Dear Dr. Scott:

I worked for the Veterans Administration as a staff optometrist for three years. The experience was very educational. Also, being able to help America's veterans was very rewarding. But due to financial considerations I had to leave the V.A. and pursue a career in the private sector.

If optometrists were to receive bonus pay for years of V.A. exmployment, as physicians do, financial considerations would not have been a factor. Should the policy change and optometrists were to receive bonus pay, I would very readily work for the Veterans Administration again.

Thank you in advance for your time and consideration regarding this matter.

Sincerely,

Karen Riccio Adams

Karen Riccio Adams, O.D.

THE
UNIVERSITY
OF
ILLINOIS
COLLEGE OF MEDICINE
AT CHICAGO

Department of Ophthalmology
1855 West Taylor Street
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Timothy McMahon, OD
Director, Low Vision Service
Director, Contact Lens Service

13 May 1987

Cliff Scott, O.D.
199 Glen Street
South Natick, MA 01760

Dear Dr. Scott:

I'm writing to you to express my concern with regard to the salary level of my former mentors and present colleagues who are practicing in the Veterans Administration Hospital system. Additionally, I'm concerned about the relatively low stipend rate that optometric residents receive for training within a residency program. I completed the optometric residency program at the Veterans Administration Hospital in Kansas City in July 1981. Shortly following completion of this program, I took a position at the Battle Creek Veterans Administration Medical Center as head of the Optometric Section. Within three months of my signing on at the Battle Creek VA, a Search Committee from the University of Illinois at Chicago, Department of Ophthalmology, offered me an academic position at their institution with a salary level in an excess of $15,000 above that which the Veterans Administration was paying. My current salary level is in the range of the highest paid Veterans Administration optometrist. Having been in practice for only six years, this is a fact I find disturbing.

A few years ago the VA established itself as a premier post-graduate clinical training ground for optometrists by having collected the highest quality clinical optometrists in the country. The competitive salaries, exciting clinical work, teaching and research opportunities as well as offering moral support to the optometric profession made the VA an attractive area to practice. Consequently, the staff optometrists generated a residency program that, to date, is the envy of all other optometric residencies and is a pattern that the other programs tend to emulate. VA residents are highly sought after due to the favorable reputation produced by their predecessors.

It has become apparent that competing institutions have learned from the VA and have begun to offer very competitive salaries to attract both new residents and to extract current attending staff from the Veterans Administration programs. This is distressing in that it appears that the Veterans Administration is not keeping pace with this new institutional competitiveness for highly skilled optometrists. I am concerned in that I know a number of mentors who have a great deal of loyalty to the Veterans Administration and financially suffer because of that. In the long run, I fear that there will be a depletion of the high quality staff that now exists in the Veterans' system and that consequently the quality of the residents turned out will diminish.

As a direct corollary, competitive institutions are beginning to offer competitive salaries or stipends for residents in training. During my residency program, the stipend level was a significant issue and was nothing short of poverty. Ophthalmology residents at our institution are paid a base salary of $24,000. This increases each year. I believe optometric residency salaries ought to be somewhere in this region.

Although I am no longer a member of the Veterans Administration staff, these concerns exist, and I still hold that institution, my mentors and colleagues in great esteem. I'd hate to see its preeminence diminish.

Sincerely,

Timothy McMahon, O.D.
Assistant Professor

TM/frh

RICK SHARP, O.D., P.C.
3748 CAUSEWAY BLVD.
METAIRIE, LOUISIANA 70002
(504) 837-8433

Mr. Dave Danielson
American Optometric Association
1505 Prince St. Suite 300
Alexanderia, VA 22314

Dear Mr. Danielson;

As you may know, optometrists in the Veterans Administration hospitals and outpatient clinics are not only underpaid but do not receive a compensatory bonus. Medical doctors do receive a bonus. The opportunities for excellent optometrists have increased tremendously during the past three years and I fail to see how one can afford to join or stay with the V.A.

I held a position at the Ft. Howard V.A.M.C. as full time staff for four years (1982-1986). The responsibility was enormous and I enjoyed the position.

I left the V.A. because I could easily DOUBLE my income and practice optometry in the same fashion as I did in the V.A. I am now the center director of an optometric referral center.

The job market for optometrists qualified to manage ocular disease is growing better and better. Unless the V.A. changes it's bonus policy I predict optometrists will be leaving the V.A. and be unwilling to take these underpaid staff positions.

The veterans, of course, will suffer the loss.

Sincerely,

R. Sharp, O.D

STATEMENT of the AMERICAN PHYSICAL THERAPY ASSOCIATION on the RECRUITMENT and RETENTION of PHYSICAL THERAPISTS by the VETERANS' ADMINISTRATION

The American Physical Therapy Association (APTA) appreciates this opportunity to address the issues of recruitment and retention of physical therapists within the Veterans' Administration (VA). Periodically over the last several years, the APTA has provided the committee with data to document the serious problem that the VA is experiencing in staffing physical therapists positions, and the conclusions that we reached were corroborated by the VA's own report to Congress in September 1986. Moreover, the VA recently completed its 1986 survey of Health Occupational Staff and determined that, of a group of seven occupations surveyed, the vacancy rate for physical therapists stood at 22.9%, a figure more than twice that of the second highest vacancy rate. Similarly, the 26.5 percent turnover rate for physical therapists was also the highest among the occupations surveyed.

The results of a survey recently completed by the APTA's Section on Veterans' Administration is attached to this statement. The survey shows that this personnel situation continues to deteriorate. In May 1987 there were 736 physical therapists employed by the VA, down from 742.4 in May 1986 and 759.8 physical therapists in December 1985. This is so despite a number of VA Medical Centers (VAMCs) reporting that they have hired more physical therapists as a result of the implementation of Public Law 98-160.

In light of this discouraging situation, the APTA is especially heartened by the VA's willingness to include physical therapists in its health professional scholarship program, and we take this opportunity to express our strong support for Section 5 of the Veterans' Administration Health - Care Personnel Act of 1987, S. 1195, which would enable this to occur.

Currently the 121 physical therapy educational programs across the country enroll approximately 8700 students of physical therapy, a projected 4300 of whom will graduate in 1988. Many of these students and those who will graduate in succeeding years are seeking ways in which to finance the costs of their education.

The fact that federal assistance for the education and training of physical therapists and other health care professionals has declined in recent years is undisputed. This new source of funding available to students of physical therapy would significant enhance the VA's recruitment potential.

While, recruitment will be enhanced by the availability of the scholarships, a bigger problem arises in terms of how to retain physical therapists after their initial recruitment. Another part of S.1195 would be instrumental in addressing personnel retention, and we strongly support the expansion of the tuition reimbursement program to include physical therapists.

But, beyond this, additional approaches are necessary. Certainly, one approach would be through implementation of special rates. This authority for this approach already rests with the VA. There is one particular problem, however, which has rendered these rates an ineffective remedy.

All of the VAMCs are experiencing financial pressures, and are not in any condition to request the authority to spend money that will have to come out of their already tightly stretched budgets. Since special rates do have to come out of their own budgets, few VAMCs are requesting them.

Many of the VAMCs that have requested special rates report that it took over five months to achieve them, rendering the rates obsolete before they could be implemented. Physical therapists within the VA system report profound frustration with attempts to convince local personnel departments to even initiate a salary survey. As a result, therapists resign from the facilities before convincing personnel officers that the VA salaries are indeed many thousands of dollars below the salaries paid in comparable local facilities.

The APTA suggests an alternative approach to the problem, and this approach relates back to Public Law 98-160. That law was meant to solve the problems of recruitment, retention and morale of physical therapists and others within the VA. While P.L. 98-160 has been especially helpful in the recruitment of new hires, it has raised further problems in retaining those physical therapists already on duty. A major reason for this complication is the manner in which it is being implemented. Any system that permits hiring new employees at a level comparable to that which current employees have reached only after several years of performance on the job is bound to have an adverse effect on the retention of current employees unless some mechanism is provided for the simultaneous reevaluation and advancement, where warranted, of those therapists already within the system.

Public Law 98-160 did provide for the review of physical therapists' qualifications and special achievements and for consequent increases in salary where warranted. This process is still underway. Yet, the problem is that there are certain therapists who may never receive recognition of their qualifications and special achievements. This is because the VA has taken the position that physical therapists in Grade 9 and above cannot be advanced above their grade despite the presence of any of the criteria that have been identified in VA Circular 00-85-9 as warranting advancement. As a result there are a number of physical therapists who are essentially being told that, although they have achieved their current level because they are valuable employees, if they want any further advancement they should start looking outside the VA.

This intransigence on the part of the VA is especially pertinent in light of the proposed revision of eligibility for the tuition reimbursement program. Physical therapists who would qualify for tuition reimbursement (as opposed to the scholarship program) would do so because they are working toward their masters degrees. Thus it becomes essential that, if the therapists are being encouraged to achieve these advanced degrees, they be provided with the opportunity for advancement once they have earned their higher degrees.

We suggest that this situation be remedied by the following steps. First, in order to place the VAMCs on a more competitive basis with the private sector, the journeyman level for physical therapists be raised from a GS-9 to a GS-10. This would mean starting newly hired physical therapists at a GS-9 as is currently the case with pharmacists.

Under this new system, physical therapists would be advanced to a GS-10 after one year. Then, after two years at the GS-10 level, the individual physical therapists would be reviewed for the development of specialization. If specialty areas had been developed in such areas as geriatrics, orthopaedics, etc., then that therapist should be advanced to a GS-11. Physical therapists who have not developed specialty areas would remain at GS-10, the newly established journeyman level.

In this same format, chiefs would also advance to a GS-12 if the staff has any GS-11s without reference to the number of the therapists supervised. Currently, a chief cannot be a GS-12 unless he or she supervises fifteen physical therapists. This also means that, unless the chief is a GS-12, none of the staff therapists can be a GS-11 because a chief has to be one grade higher than staff therapists. We understand that these changes could be made within the VA in a relatively expedient manner, if only the VA decided to do so.

Upward mobility is the primary element that is lacking in the VA, and that is the long term advantage that the private sector has to offer. The May 1987 survey which I cited earlier, and which is attached, shows that the largest number of vacancies in VA physical therapy slots occurs at steps two through five of the GS-9 level. The survey documents the last vacancy and where possible the last two vacancies at 94 of the VAMCs, and it shows that, of the 127 vacancies that have occurred in GS-9 physical therapist positions, 91 of those vacancies resulted from a therapist leaving a slot in the lower half of the grade.

These are individuals who have been at the GS-9 level for several years and recognize the lack of career advancement. These therapists are not yet heavily vested in retirement and have little incentive to remain in what is essentially a "dead end" position. The VA could retain their expertise, however, through the creation of a "career ladder" as we have suggested.

In conclusion, the APTA appreciates the approaches being taken to facilitate the recruitment and retention of physical therapists in the VA by those portions of S. 1195 which make physical therapy students eligible for the scholarship program and which would include physical therapists among those eligible for tuition reimbursement. Beyond this, however, we urge the Committee to seriously and expeditiously consider the other remedies we have suggested as viable solutions to a problem recognized by all concerned.

The VA cannot be expected to provide our veteran population with the quality care those veterans deserve unless it has in place a mechanism that can attract the health care professionals to provide that care. We appreciate this opportunity to work with the Committee to develop solutions to this situation.

Respectfully submitted,

R. Charles Harker, Esq.
Director of Government Affairs
APTA
6/11/87

VETERANS' ADMINISTRATION MEDICAL CENTER

PHYSICAL THERAPY STAFFING STATISTICS—DECEMBER 1985 - MAY 1987

	AUTHORIZED PT's 12/85	AUTHORIZED PT's 5/86	AUTHORIZED PT's 5/87	VACANCIES 12/85	VACANCIES 5/86	VACANCIES 5/87	GRADES OF LAST TWO VACANCIES
ALABAMA							
Birmingham	3	3	2	1	1	1	9/2, 9/10
Montgomery	1	1	1	0	0	0	9/1, 11/7
Tuscaloosa	3	3	3	1	1	1	11/1, 11/10
Tuskegee	4	4	4	0	0	0	
ARIZONA							
Phoenix	5	5	4	0	2	4	11/6, 9/7
Prescott	3	3	2	1	1	1	9/1, 9/3
Tucson	4	4	4	0	0	1	11/9, 9/10
ARKANSAS							
Fayetteville	2	2	2	0	0	0	
Little Rock	8	10	8	4	5	2	9/4, 9/6
CALIFORNIA							
Fresno	4	5	4	3	3	1	9/4
Livermore	3	2	4	1	0	2	
Loma Linda	5	5	5	0	0	0	
Long Beach	18	18	15.5	1	1	2	10/5, 9/3
Los Angeles (Wads.)	11	15	9	4	0	1	
Martinez	6	5	9	0	0	2	9/2, 9/2
Palo Alto	6	6	15	0	1.5	6	11/8, 9/3
San Diego	6	6	6	1	0	1	9/10, 9/6
San Francisco	4	6.5	5.5	2	3.5	2	11/7, 9/3
Sepulveda	7	6	5	1	1	0	
COLORADO							
Denver	8	6.4	6.4	0	0	0	9/1, 9/3
Ft. Lyons	1	1	1	1	1	1	11/8, 9/1
Grand Junction	2	2	2	0	0	0	9/4, 9/3
CONNECTICUT							
Newington	4	3	4	0	1	1.5	9/2, 9/2
West Haven	6	5	7	0	1	5	9/6, 9/5
DELAWARE							
Wilmington	1	1	1	1	1	1	9/5
DISTRICT OF COLUMBIA	8	8	8	2	3	3	9/2
FLORIDA							
Bay Pines	6	5	4	1	2	0	9/2, 9/5
Gainesville	6	6	4	0	1	0	9/1, 11/5
Lake City	1	3	1	0	2	0	
Miami	12	11	11	1	0	0	11/9, 9/2
Tampa	11	10	10	2	3	3	9/10, 9/8
GEORGIA							
Atlanta	7	7	7	1	1	1	
Augusta	10	10	9	2	3	0	9/2, 9/2
Dublin	2	3	2	0	2	0	

PHYSICAL THERAPY STAFFING STATISTICS--DECEMBER 1985 - MAY 1987

	AUTHORIZED PT's 12/85	AUTHORIZED PT's 5/86	AUTHORIZED PT's 5/87	VACANCIES 12/85	VACANCIES 5/86	VACANCIES 5/87	GRADES OF LAST TWO VACANCIES
IDAHO							
Boise	4	4	4	0	0	1	9/3
ILLINOIS							
Chicago (Lakeside)	5	5	3	2	2	2	9/7, 9/7
N. Chicago	6.5	7	5.9	3	4	1.5	9/5, 9/4
W. Chicago	4	4	7	1	1	3	11/3, 9/2
Danville	5	4	4	4	3	3	10/10, 9/2
Hines	10	11	13	5	6	6	9/2, 9/2
Marion	1	1	1	1	1	1	
INDIANA							
Ft. Wayne	1	1	0	0	0	0	
Marion	3	3	2	2	1.5	0	
Indianapolis	5	6	5	2	3	0	
IOWA							
Des Moines	2	2	2	0	1	0	
Iowa city	2	2	2	1	1	1	
Knoxville	4	3	3	1.5	1	1.5	
KANSAS							
Leavenworth	5	5	5	2	1	0	9/5, 11/10
Topeka	4	5	5	0	1	1	9/4, 9/7
Wichita	4	3.5	3.5	1.5	1	2	9/6, 9/6
KENTUCKY							
Lexington	8	7	7.5	2	1	0	9/6, 9/4
Louisville	3	3	3	1	1	2	9/6, 9/5
LOUISIANA							
Alexandria	1	1	3	0	0	2	
New Orleans	2	2	3	0	1	2	9/3, 9/2
Shreveport	3.5	3	3	1	1	2	9/3, 9/7
MAINE							
Togus	5	5	6	1	0	1	9/4, 9/4
MARYLAND							
Baltimore-Ft. Howard	5	5	3	0	1	0	9/2
Perry Point	2	3	3	0	2	1	6/1
MASSACHUSETTS							
Bedford	8	8	8	4	4.5	3.5	9/10, 10/1
Jamaica Plains (Boston)	11	12.2	15.2	0	0	2	9/1, 9/2
W. Roxbury-Brockton	9	4	14	2	0	2	10/4, 9/5
Northampton	5	5	4	0	1	1	9/7, 9/2
MINNESOTA							
Minneapolis	9	9	9	1	3	0	9/10, 9/10
St. Cloud	3	3	2	1	1	0	9/7, 9/5
MICHIGAN							
Ann Arbor	7.3	7.3	7.5	1	1	1	10/4, 9/7
Battle Creek	3	3	3	1.5	3	2.5	10/10, 9/10
Allen Park (Detroit)	4	4	4	4	4	0	
Iron Mountain	3	3	2	1	1	0	
Saginaw	2	2	1	2	2	0	

PHYSICAL THERAPY STAFFING STATISTICS--DECEMBER 1985 - MAY 1987

	AUTHORIZED PT's 12/85	AUTHORIZED PT's 5/86	AUTHORIZED PT's 5/87	VACANCIES 12/85	VACANCIES 5/86	VACANCIES 5/87	GRADES OF LAST TWO VACANCIES
MISSISSIPPI							
Biloxi-Gulfport	5	5	2	3	3	1	9/4, 11/1
Jackson	4	4	4	0	0	0	9/3, 9/3
MISSOURI							
Columbia	5	5	5	1	0	0	10/1
Jeff. Barr.-Cochran	9	13	10.5	1	0	0.5	11/5, 9/2
Kansas City	4	4	4	0	0	0	9/10
Poplar Bluffs	0	0	2	1	1	1	10/5
MONTANA							
Helena	1	1	1	0	0	0	
Miles City	0.6	1	1	0	1	1	
NEBRASKA							
Grand Island	2	2	1	1	1	1	
Lincoln	2	2	3	1	1	1	
Omaha	6	4	6	1	0	0	
NEVADA							
Reno-Las Vegas	4	3	4	1	0	1	9/7
NEW HAMPSHIRE							
Manchester	3	3	3	1	1	1	GS-10
NEW JERSEY							
East Orange	4	4	5	3	4	5	GS-10
Lyons	2	2	2	1	1	1	9/6, 9/4
NEW MEXICO							
Albuquerque	4.5	7	7	0	0	0	9/8, 7/7
NEW YORK							
Albany	4	4	3	1	1	0	9/1
Bath	3	2	2	1	0	0	
Batavia	5	5	4	1	1	1	
Brooklyn	9	9	1	5	6	1	9/1
Buffalo	9	9	7	1	0	0	
Canandaigua	3.6	4	5	0	0	1	9/1
Castle Point	2.5	2.4	4	1	1	1	9/1
Montrose	2	2	4	1	0	2	9/1
New York (Manhattan)	15	5	14	9	4	11.4	
Bronx	5	5	10	3.5	3.5	3	
Northport	11	11	11	6	5	6	9/1
Syracuse	5	5	4	0	0	1	9/1
NORTH CAROLINA							
Asheville	3	2	2	0	0	0	9/5, 9/5
Durham	4	4.5	4	0	0.5	0	9/5, 9/1
Fayetteville	3	3	2	1	2	2	
Salisbury	3	3	2	2	1	2	
NORTH DAKOTA							
Fargo	3	3	2.5	0	0	0	

PHYSICAL THERAPY STAFFING STATISTICS—DECEMBER 1985 - MAY 1987

	AUTHORIZED PT's 12/85	AUTHORIZED PT's 5/86	AUTHORIZED PT's 5/87	VACANCIES 12/85	VACANCIES 5/86	VACANCIES 5/87	GRADES OF LAST TWO VACANCIES
OHIO							
Cleveland-Brecksville	5.75	5	3.25	3	2.5	3	9/7, 9/8
Chillicothe	3	3	3	2	2	2	9/2, 9/3
Cincinnate	4	4	4	0	0.5	1	9/5, 9/10
Dayton	6	6	5	1	1	0	9/4
OKLAHOMA							
Muskogee	3	3	2	0	0	0	10/9, 9/1
Oklahoma City	5.75	5.75	5.75	0	2	0	7/7, 9/3
OREGON							
Portland	6.5	7.5	7.5	1.5	0	2	
Roseburg	4	2	4	1	0	1	
White City	2	1	1	2	0	1	11/2
PENNSYLVANIA							
Altoona	3.7	3.7	1	2.7	3.7	0	
Butler	1.5	1.5	4	0	0	2.88	GS-10, 9
Coatesville	3	3	3	0	0	2	
Erie	1	1	1	0	0	0	
Lebanon	5	5	5	2	2	1	
Philadelphia	4	3	4	1	1	1	9/3, 9/4
Pittsburgh	8	8	3	5	6	0	
Wilkes-Barre	9	9	7	3	3	0	
RHODE ISLAND							
Providence	5	5	4	0	0	0	9/4, 9/5
SOUTH CAROLINA							
Charleston	2	2	3	1	1	0	
Columbia	4	4	4	1	1	1	
SOUTH DAKOTA							
Ft. Meade	1	1	1	0	0	0	
Souix Falls	4	5	4	2	3	1	
Hot Springs	1	1	1	0	1	0	
TENNESSEE							
Nashville	3	3	3	2	2	2	9/8, 7/1
Memphis	11	11	8	9	4	5	
Mountain Home	5	4	4	1	0	0	
Murfreesboro	6	4	4	2	2	1	
TEXAS							
Amarillo	1	1	1	0.2	0.2	0	
Big Spring	2	2	2	1	1	0	
Dallas	5	5	4	1	3	2	7/3, 9/10
Houston	8	7	7	1	1	3	9/2, 11/5
Kerrville	2	2	2	1	0	0	9/2, 9/3
Marlin	1	1	1	1	0	0	
San Antonio	5	6	9	1	1	2	9/4, 9/3
Bonham	2	0	1	1	0	0	
Temple	4	4	3	0	0	1	
Waco	4	4	2	1	2	2	11/10, 9/10

THE MOUNT SINAI MEDICAL CENTER
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OF THE CITY UNIVERSITY
OF NEW YORK

Mount Sinai School of Medicine • The Mount Sinai Hospital

Gerald and May Ellen Ritter
Department of Geriatrics
and Adult Development

Testimony of Robert N. Butler, M.D.

Brookdale Professor of Geriatrics and Adult Development

Chairman, Gerald and May Ellen Ritter

Department of Geriatrics and Adult Development

The Mount Sinai Medical Center

New York, New York

Submitted to the Committee on the Veterans' Affairs on

"The Veterans' Health Care Improvement Act of 1987"

June 15, 1987

Thank you Mr. Chairman for the opportunity to testify on the importance of the Veterans' Administration's role in the training of health professionals and the need for basic research on all aspects of aging. Section 10 of S.6 of the proposed Veterans' Health Care Improvement Act of 1987 is an important step toward improving geriatric education and research, but it is only a first step. In addition to the report Congress needs to ensure that any recommendations which will improve geriatrics education and research in this country are quickly implemented. The VA must make significant headway in the training of doctors in geriatrics if it is to meet the critical needs of our aging veterans.

THE AGING REVOLUTION

America and the VA are witnessing one of the greatest revolutions in history; the Age of Aging. It is the first period in history when any child can expect to see old age. In 1980, 70% of all Americans could expect to reach 65 years of age and fully 17% could expect to reach 85 years of age. Although the VA is not alone in facing the aging of its population, it will face the demographic realities earlier than the rest of America.

The Aging Veteran

Of the 27.8 million veterans living in the United States and Puerto Rico, 19% are already 65 or older. In 1985, the median age for veterans was 52.9 years. Since 37% of all Veterans are World War II veterans quickly approaching 65 years of age, the number of veterans at least 65 years of age will increase by 69% from 5.3 million to 8.9 million within the next 12 years. Furthermore, the mobilization pattern in World War II was so extensive that, by the turn of the century, fully 63% of all American males over 65 will also be veterans.

Merely recognizing the increase in the number of elderly veterans understates the intensity of services required. Currently the 12% of our population over 65 accounts for more than 33% of the use of physican time, 25% of medications and 40% of acute hospital admissions. In 1980 persons over 65 years of age made 165 million physician visits. Consequently, the great increase in the number of elderly persons eligible for V.A. services requires services which are qualitatively and quantitatively different from VA services to nonelderly.

The VA will also face the need to provide an unprecedented amount of long-term care for aged veterans. The group most likely to be institutionalized are the "old-old", those 85 or older. Yet this is the fastest growing age group in America. By the end of the century the 2.7 million currently 85 or older will double to 5.4 million.

THE VETERANS ADMINISTRATION'S ROLE

Since World War II the Veterans administration has played a key role in medical education when the VA needed to expand its services and medical schools wanted to meet the demand for resident training from returning military physicians. Medical school expanded from residency training to clinical clerkships for medical students. Research activities and medical training are now an integral part of the 172 Veteran Administration Medical Centers.

The VA is affiliated with 101 medical schools, 59 dental schools and 850 other health care professional schools and must use its leverage with all these health care providers to stress the importance of geriatric research and education. The VA report can indicate what measures are currently in place to help the VA meet the upcoming demands on its service.

Emphasize Geriatrics Education and Research

In 1975 the VA again asserted its medical leadership by recognizing the growing need for geriatric research and training through the establishment of the Geriatric Research and Education Clinical Centers (GRECCs). Some of the centers have served as models for geriatric training. Some have conducted fine geriatric researh. All have proved that elderly patients require different services than non-elderly. All have reinforced the need for more geriatrics training and much more research on all aspects of aging.

The VA currently supports geriatric residency training by funding a small number of resident positions specifically to encourage geriatrics rotations. Yet only 40% of medical residencies even offer geriatrics rotations. Again, it appears that few residents choose geriatrics rotations. Do all VA affiliated medical schools offer geriatrics courses and rotations? How many encourage rotations through one of the affiliated nursing home care units? What has the VA's experience been with the geriatrics rotations it has encouraged? Are there other ways the VA can stimulate geriatrics rotations within other specialties? These are only a few of the important questions the report can answer.

In the fellowship area, the VA supports about half the fellows trained annually in geriatrics. These fellows' positions are crucial in training the next generation of leaders critical to the establishment of geriatrics as an academic specialty within the medical field. They are also essential to the development of research on aging. At a minimum, these funds must be maintained. Given the projected need for geriatricans in the next two decades, these funds should be expanded.

Mainstreaming Geriatrics Education

In their report, the Veterans Administration should examine the geriatrics training of medical students and residents. A recent Institute of Medicine report summarized in the New England Journal of Medicine revealed that although 75% of U.S. medical schools offer elective courses in geriatrics only four percent of the medical school students take these courses. I believe all medical schools should require their medical students to have a rotation through geriatrics as Mount Sinai in New York does. If the VA is to cope with the crisis from the impending cohort of aging veterans, it must use its leverage with its affiliated schools to expose many more doctors to the important issues in geriatrics. Medical doctors must recognize that during the next two decades, the majority of their practice will be for patients over 65 years of age.

Coordinate Geriatrics Fellowships with other Federal Agencies

The twelve VA Medical Center Geriatric Research and Education Clinical Centers (GRECCs) have improved geriatric services but more can and must be done outside the twelve GRECCs. The VA needs to coordinate its strong medical leadership in geriatrics with other federally funded research training programs offered by Health and Human Services (HHS) and the National Institute on Aging (NIA). The GRECCs must work with the medical school based Geriatric Education Centers to coordinate research and fellowship training.

In a time of very limited resources, it is crucial that the VA work with other governmental agencies and private foundations to establish premier geriatric research and education centers. So few physicians have geriatric training and so many veterans will require geriatric services over the next decade that I beseech you to require coordination of the minimal funds spent on geriatric training in this country.

Enhance the Organizational Stature of Geriatrics within the Veterans' Administration

The VA must highlight geriatrics as an important concern in all aspects of VA medical service. To emphasize geriatrics requires the VA report to review the organizational placement of geriatrics within the veterans administration's central offices. If geriatrics is to become a key issue for the next decade, its organizational structure must be enhanced to reflect that importance. I hope the report will make recommendations about the placement of geriatrics within the VA organization.

Support the Continuing Education Efforts

The VA offers some fine programs with very limited resources for the continuing education of physicians. A number of excellent national conferences have been sponsored or co-sponsored by the VA. The regional medical education centers have also offered programs in geriatrics and have encouraged the attendence of practicing physicians in the area. If the report analyzes the number of geriatric oriented programs offered in comparison to other issues and then breaks down the response by region, I'm certain that the committee would gain valuable insights into the considerable variations across the country as to the importance of geriatrics continuing education programs.

Strengthen Research in Geriatrics

Traditionally the VA has been an important contributor to medical research in bio-medical research as well as health services delivery. Much of the innovative work in alternatives to long term care institutionalization has been supported by research and demonstrations sponsored by the VA. The VA has expanded its work to include an array of services in its Hospital Based Home Care services. This work deserves to be praised and continued.

VA doctors also need to continue to work with other professionals to coordinate research on service delivery for the older patient. The VA must leverage its considerable financial support for training in many health professions to encourage specific research on health problems of the elderly. The report should also consider the VA's role in the training of home health aids and nursing home aids. Respite care and adult day care needs are becoming increasingly important components of the long term care needs and the VA may have to cope with training these aids.

Mainstream Research In Geriatrics

Research in geriatrics need not be limited to those clinicians trained in geriatrics. All areas of medical specialty can improve their research on the cohort of older patients and integrate the effects of age into their research. Many VA hospitals are a natural place to conduct fine research on many different aspects of aging and we should know how many conduct this research. We need to find out how the VA can provide incentives so more doctors and other health professionals will conduct research on the physical and psychological issues of the aging veterans.

Although funds for sponsored research are scarce and should not come at the expense of other important work, the VA needs to find the resources and the will to enhance research on the problems of aging veterans. Despite tight budgets, the criticality of the problem cries out for solid research in many medical specialties and across many health professions. Creative approaches are possible if the VA chooses to emphasize aging as an important area of research. We face an impending deluge of patients and we have not developed the knowledge base to cope with them.

Fully Fund the Authorized Number of Geriatric Research and Education Centers

The VA should increase number of GRECCs to at least the fifteen originally authorized. Although the quality and quantity of its research in geriatrics can be improved in many other settings as well, the VA should continue to expand the GRECCs. These centers can help spawn the seminal research in geriatrics which must be conducted if this country expects to improve the lives of our elderly citizens. Congress authorized fifteen and the Congress and the VA need to identify and fund at least the three new sites.

Act on the Report's Recommendations

I hope that the report will analyze the issues I've discussed and prepare meaningful recommendations. Once these recommendations are put forward, I trust that Congress will ensure that these are enacted quickly. It may be difficult to find the resources but the need is real, growing and will not go away. Congress must provide the leadership to meet the critical and imminent demands which the VA faces. We can not reneg on our committment to those who served our country. Their courage and honor should not be demeaned in old age by a medical system and an administraion unwilling to meet its obligations.

Celebrating 75 Years 1912 1987
Advancing Foot Health . . .
Enriching the Quality of Your Life!

American Podiatric Medical Association

June 8, 1987

The Honorable Alan Cranston
Chairman, Committee on Veterans Affairs
U. S. Senate
414 RSOB
Washington, D.C. 20510

Dear Mr.Chairman:

With regard to S. 1125, which you introduced "by request" on May 1 and on which hearings were held on May 21, I write to register a concern we have with the measure. I refer to that portion of the bill which would grant authority to the Chief Medical Director, with the approval of the Administrator, to "...establish, considerate, eliminate, abolish, redistribute, or modify such positions and offices as he deems needed for the Department of Medicine and Surgery to carry out its missions."

As you will recall, the Administration has previously sponsored proposals to remove from the statutes the requirement for selected Central Office services, including the Podiatric Service. Those initiatives with your understanding and support were properly shelved as I am hopeful this one will be. We view this provision of S. 1125 as a back door attempt to achieve the same objective and to do so in the name of streamlining Central Office Administration.

Mr. Chariman, the Congress has been required over the years to direct the VA Central Office to respond to a variety of problems and service needs. Without those direc- tives, the rigidity of the bureaucracy would have precluded a needed response to those problems and needs. This has most certainly been true with the Central Office Podiatric Service, whose hospital based programs have experienced phenomenal growth since 1977. We can not support anything that offers the potential of disturbing that progress which, based on the Administration's past performances, could result from the passage of S. 1125.

Appreciating your continuing understanding and support, I am

Yours Truly,

John R. Carson

20 Chevy Chase Circle, N.W. • *Washington, D.C. 20015* • *202-537-4900*

American Optometric Association
1505 Prince Street ● Alexandria, VA 22314 ● (703) 739-9200

June 8, 1987

The Honorable Alan Cranston
Chairman, Committee on Veterans Affairs
SR 414 Russell Senate Office Building
Wasnington, DC 20510

Dear Mr. Chairman:

The American Optometric Association herewith offers comments upon S. 1125, a bill which modifies the structure of the Office of Chief Medical Director. This Association opposes a provision of S. 1125 which, we conclude, will adversely affect the delivery of vision care to the veteran population.

Specifically, we are concerned that a portion of S. 1125 (lines 6&7, page 2) will bring to an end a decade of success in providing improved and cost-effective eye and vision care to our nation's veterans. S. 1125 gives the VA's Chief Medical Director the authority to create and abolish clinical services directorships in VA Central Office. We are convinced that such an administration request (we understand S. 1125 was introduced by request of the VA) has as its targets the smaller non-medically directed clinical services such as optometry and podiatry. Our reason for concern that lines 6&7, page 2 of S. 1125 is directed at optometry (and podiatry) is from past experience of VA requested initiatives which have sought to abolish the optometric and podiatric directorships by name. The first VA legislative request appeared in 1983 as H.R. 2786. The wording of that bill was to the effect that the CMD would "make optional the appointment of Directors of the Optometric...Services."

Other later VA requests (eg. S. 2172, H.R. 3763) diffused the language, we imagine, in an effort to defuse the obvious attempt to emasculate the optometry program by using verbage more akin to the present bill at issue, S. 1125. The effect will be the same--optometry and podiatry are sure to be targets--but this extent language can be protrayed as including all clinical service directorships. Again, we are convinced the targets of this section are the optometry and podiatry directorships.

Not only is the AOA adamantly opposed to this part of S. 1125 (lines 6&7, page 2), but its thrust runs counter to the explicit findings of Congress when it passed the Veterans' Ominibus Health Care Act of 1976 (PL 94-581), which created an Optometric Service, and Director of the Optometric Service.

The Congress found that the numbers of optometrists employed by the VA (in 1976) were "substantially below the numbers indicated by the size, age and demographic characteristics of the VA patient population." The Congress continued to explain there were several barriers which may have prevented hiring optometrists but, "Chief among these are the absence of Optometric...Services in Central Office to coordinate recruitment and retention efforts and enhance the professional status of these personnel." (legislative history attached).

To further underscore the need for a director of the VA's optometry program, the Government Accounting Office in its 1978 report, "Role and Use of Optometry in the Veterans Administration Need Improvement" concluded the VA's optometry program needed optometric direction. In fact, GAO recommended more direction from VA Central Office (GAO report pages i,ii, 21, 23, 24 attached).

Curiously, over the past decade, the VA has repeatedly gone on record to support the expansion of eye and vision care services, yet the agency proposes to abolish the optometry directorship. It seems incongruent that the VA on the one hand has proposed expansion of eye care, budget permitting, while on the other hand anticipates the evaporation of the Service Director position. One would assume in light of the often-announced intentions to expand eye care there would be more need for direction from Central Office for this program, not less, or under the S. 1125 proposal, none at all.

To reiterate, the American Optometric Association is opposed to that portion of S. 1125 which eliminates statutory authority for the Director, Optometric Service because we feel it would doom the VA's optometry program and deny our nation's eligible veterans a valuable health care service; a service which the Congress, the Government Accounting Office and the VA itself have found to be a beneficial and cost-effective component of veterans' comprehensive health care entitlement.

Sincerely,

James W. Clark, Jr.

James W. Clark, Jr.
Washington Office Director

JW/lb

cc: Mr. Brew
Ms. Masters
Ms. Isaacson

Calendar No. 1140

94TH CONGRESS }
2d Session }

SENATE

{ REPORT
{ No. 94–1206

VETERANS' OMNIBUS HEALTH CARE ACT OF 1976

REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

TO ACCOMPANY

S. 2908

SEPTEMBER 3 (legislative day, AUGUST 27), 1976.—Ordered to be printed
(Filed under authority of the Senate of SEPTEMBER 1 (legislative day,
AUGUST 27), 1976

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contribute to the quality of practice in VA facilities beyond their direct contribution to patient care. They create the atmosphere of questing minds and stimulating ideas that makes for progressive medical and dental care, that welcomes new advances but is cautious in evaluating them, and that is prepared for changing patterns of health care.

Second, the availability of research facilities and support money has consistently been shown to be an important factor in the recruitment and retention of physicians, and any reduction in the size or quality of the DM&S's research effort would have an immediate adverse impact on the VA's ability to recruit new physicians and retain the physicians already on board.

And third, the DM&S research program has been an important part of the affiliation process between VA hospitals and medical schools, which in turn has been one of the major contributing factors to the improvement in VA patient care during the past three decades. Slippage in the quality of the DM&S research program or in the commitment of the VA to a continuing viable program of biomedical research could jeopardize some of the VA's major academic affiliations.

It is essential that Congress continue to demonstrate its firm resolve to keep the VA research program on strong footing. Now that the fiscal year 1977 research budget has been strengthened somewhat, the Committee believes that one further step is needed to ensure that VA clinical researchers continue to be among the best in American medicine. Research positions in the Department of Medicine and Surgery have traditionally been prestigious, and have been filled by many of the ablest young physicians and dentists in the VA system. The Committee believes it is counterproductive and inequitable with respect to the medical research program and damaging to the quality of care in VA hospitals to create a financial disincentive for service as a clinical researcher by excluding researchers from eligibility for special pay.

Section 122(b) of the Committee bill therefore would amend section 4118 of title 38 to mandate the payment of special pay to all physician and dentist clinical researchers who are otherwise eligible for special pay. This would technically be done by authorizing, under subsection (a)(1) of section 4118, the payment of special pay to physicians or dentists serving in "professional or administrative positions or clinical research positions in the career development program", and then limiting the categories of physicians and dentists which may be excluded from special pay by the Chief Medical Director, under subsection (a)(3) of section 4118, to those serving in "professional and administrative positions" only—the clear result being that the Chief Medical Director is not authorized to exclude clinical researchers pursuant to this subsection (a)(3) discretionary administrative authority.

The Committee believes that this provision will make a major contribution to the restoration of morale among DM&S's clinical researchers and the continuation of the research program's vital role in the improvement of health care for all veterans.

Recruitment and Retention of Optometrists and Podiatrists

The Department of Medicine and Surgery currently employs only 8 full-time optometrists and 20 full-time podiatrists. By any conceivable measure, these numbers are not enough to meet the demand for optometric and podiatric services in the VA health care system. Recent surveys of the DM&S patient population, for example, reveal that two-thirds of all veterans screened required some type of optometric service; because of the paucity of trained optometrists, however, less than 1 in 10 veterans received such services. Although optometrists outnumber ophthalmologists by a ratio of 2 to 1 in the United States, there are 6 full-time VA ophthalmologists for every full-time VA optometrist. This clearly implies that highly-trained ophthalmologists are performing the functions that could more effectively and inexpensively be done by optometrists. Similarly, although there are approximately three podiatrists for every 100,000 American citizens, the VA employs only 1.6 podiatrists for every 100,000 hospitalized veterans.

It is clear to the Committee that the numbers of optometrists and podiatrists employed by DM&S are substantially below the numbers indicated by the size, age, and demographic characteristics of the VA patient population.

The Committee identified several barriers which may have deterred or prevented the hiring of more optometrists and podiatrists in DM&S. Chief among these are the absence of Optometric and Podiatric Services in Central Office to coordinate recruitment and retention efforts and enhance the professional status of these personnel; the lack of continuing medical education opportunities for optometrists and podiatrists; and, most importantly, noncompetitive salaries, particularly at the mid- and advanced-career levels.

Under current law, optometrists and podiatrists are paid in accordance with the General Schedule for Federal civil service employees under title 5, United States Code. The normal starting salary for optometrists and podiatrists in the VA is $13,482 (GS–9, step 1), with advancement to a normal career salary of $21,113 (GS–11, step 10)—well below the average salary of $30,000 for optometrists and $32,000 for podiatrists in private practice. The unfortunate result of these below-average salaries has been that virtually every VA optometrist and podiatrist operates a small private practice in the evenings or on weekends in order to supplement their full-time VA salary—a circumstance which, in the Committee's view, is neither fully consistent with their professional stature as full-time members of the VA health care team nor fully conducive to high-quality patient care.

Section 113(b) of the Committee bill would amend chapter 73 of title 38 in order to enhance the recruitment and retention of optometrists and podiatrists in DM&S. Full Optometric and Podiatric Services would be created in Central Office, each headed by a Director responsible to the Chief Medical Director for the operation of his or her Service. Optometrists and podiatrists (as were physician assistants and expanded-function dental auxiliaries in the 1975 Public Law 94–123) would also be removed from the Federal civil service system under title 5, placed in the title 38 pay and personnel system, paid in accordance with a new "Clinical Podiatrist and Optometrist Schedule" to be added to section 4107 of title 38, and generally made part of the DM&S title 38 personnel system subject to the rules and procedures of chapter 73 of title 38 and implementing regulations thereunder. Under the new pay schedule, salaries would range from $16,255 to

$37,800, amounts substantially more in line with comparable non-VA starting and career salaries for these health professionals.

The Committee strongly believes that increased utilization of optometrists and podiatrists by DM&S would be cost-efficient and would significantly expand the scope of the health care program. The addition of optometrists and podiatrists in significant numbers would free ophthalmologists and orthopedic surgeons to perform the diagnostic and surgical procedures for which they were specially trained, and would thus result in a higher quality of health care for more veterans at a lower cost.

It is hoped that making optometrists and podiatrists part of the title 38 system will enhance their opportunities for greater professional status, more appropriate pay and working conditions, and professional and academic associations with institutions of higher learning.

Recruitment and Retention of Other Non-physician Personnel

The starting salaries of health care employees in the VA health care system (other than physicians, dentists, nurses, physician assistants, and expanded-function dental auxiliaries) are fixed by Civil Service Commission pay and job standards. These salaries are in some cases several thousand dollars below those offered employees for comparable positions in non-VA facilities. This differential between VA and non-VA starting salaries is one of the most important non-physician recruiting problems facing the Department of Medicine and Surgery.

To assist the DM&S in recruiting qualified non-physician personnel, section 113(a) of the Committee bill authorizes the Administrator of Veterans' Affairs to adjust the minimum and maximum salaries within grade, on a nationwide basis, for any category of health care personnel (except physicians) when such an adjustment is deemed necessary to aid in the recruitment of such personnel. Under the new subsection (g) to be added to section 4107 of title 38, adjustment could be ordered only for one of three specific purposes: (1) To provide pay "commensurate with competitive pay practices in the same occupation", (2) to achieve "internal alignment of rates of basic pay" in the Department of Medicine and Surgery, and (3) to attract or retain certain shortage category personnel for employment at VA health care facilities.

This provision is virtually identical to one contained in section 4(d)(3) of the Senate-passed version of legislation (S. 1711) enacted last year as Public Law 94-123, the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975. The provision was deleted from the pay comparability bill before enactment.

The following example best explains the assistance subsection (g) is designed to provide to DM&S: Assume a person who enters the VA at GS-3, or $7,102 a year. Were the Administrator to determine (1) that, on a nationwide basis, persons in that category of personnel in non-VA facilities generally started at higher salaries than VA personnel in that category, and (2) that the salary differential had generated a recruitment problem for the VA, then he could raise the starting salary for persons in that category from $7,192 to as much as $9,235, the maximum salary under GS-3, step 10. The new subsection (g), in short, would give the Administrator considerable flexibility within grades, where necessary, to adjust VA starting pay and to make VA salaries more competitive with those offered by other health care facilities.

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Release
7/3/78

REPORT BY THE
Comptroller General
OF THE UNITED STATES

Role And Use Of Optometry In The Veterans Administration Need Improvement

Studies showed that a significant percent of veterans who seek medical care in Veterans Administration facilities also have eye or vision disorders which require some form of treatment. Many of them may not be receiving needed eye or vision care because VA has only a limited number of providers of this type of care--mostly ophthalmologists.

One way to meet the workload would be to expand the role and number of optometrists in the VA health care system. VA has not done so because of a number of problems.

GAO made this review at the request of the Chairman of the Subcommittee on HUD–Independent Agencies, Senate Committee on Appropriations.

HRD-78-129
JUNE 21, 1978

COMPTROLLER GENERAL'S
REPORT TO THE SUBCOMMITTEE
ON HUD-INDEPENDENT AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE

ROLE AND USE OF OPTOMETRY IN THE VETERANS ADMINISTRATION NEED IMPROVEMENT

DIGEST

There is a need for the Veterans Administration (VA) to expand its eye/vision care services for eligible veterans seeking medical care and treatment at VA medical facilities.

Based on available information, a significant percent of veterans have eye/vision disorders which require some type of care and/or treatment. Under VA's present eye/vision care program, many of these veterans may not be receiving needed care and treatment.

One alternative in meeting the eye/vision care needs of veterans would be to expand VA's use of optometrists. These individuals are specifically trained to examine eyes to determine eye/vision abnormalities, prescribe corrective lenses, and refer patients with suspected diseases or injuries to physicians. Experience at the Birmingham and other VA medical facilities, as well as other health care systems, has demonstrated that the use of optometrists has been beneficial to patient care.

In comparison to other health care systems, VA employs few optometrists, even though recent legislation improved its ability to recruit and retain optometrists. Furthermore, VA participates in few optometric training programs, although legislation authorized it to participate in such programs in cooperation with schools and colleges of optometry.

VA has made an effort to improve its eye/vision care program by employing optometrists and participating in academic affiliations with schools and colleges of optometry. However, VA's efforts have been hindered because of resistance from ophthalmologists, space and/or funding limitations, and lack of adequate direction and planning from VA Central Office.

To date, VA has done little to overcome these problems. VA Central Office has delegated its central management responsibilities to individual hospital and clinic directors. In view of the limited success of expanding optometric programs in these hospitals and clinics, GAO believes that the Central Office should assume a more active role to insure that the development of such programs is successful.

RECOMMENDATIONS

The Administrator of Veterans Affairs should direct the Chief Medical Director to:

--Determine the adequacy of existing optometrist/ophthalmologist staffing and eye/vision care programs at each VA medical facility for meeting the needs of veterans seeking care and treatment.

--Develop eye/vision care programs using both optometrists and ophthalmologists to strengthen those programs considered to be inadequate.

--Develop guidelines which set forth optimal optometrist/ophthalmologist staffing levels and the roles and responsibilities of optometrists with emphasis on their interaction with ophthalmologists in VA medical facilities.

--Increase VA's participation in the education and training of optometrists in cooperation with schools and colleges of optometry.

At the request of the Subcommittee, VA was not given the opportunity to provide written comments on the report before its release to the Subcommittee. GAO did discuss these matters with agency officials and has included their comments, as appropriate.

the hospital or the St. Albans Division was not possible because it had space limitations and was committed to a number of new programs developed to strengthen its medical school affiliation.

Houston, Texas, VA Hospital

In December 1977 VA's Director of Optometric Service wrote the chief of staff at the Houston VA Hospital indicating he would authorize and fund a full-time optometrist position at the Houston hospital if the hospital would provide adequate space and affiliate with a college of optometry. Previously, the hospital had informally advised the director of its desire to employ an optometrist and that space might be made available in a neighboring building. However, in responding officially to the director's offer, the hospital director stated that suitable space was not available for an optometry program. VA's Director of Optometric Service believed that the department of ophthalmology at the affiliated medical school had influenced the hospital's decision.

OPTOMETRY PROGRAMS NEED DIRECTION FROM CENTRAL OFFICE

Although VA's Ophthalmological Advisory Committee had endorsed a policy of cooperation between optometrists and ophthalmologists in 1975, VA Central Office had not, as of March 1978, been effective in implementing many new optometry programs throughout the VA health care system.

VA's Director of Optometric Service said that the primary responsibilities of his office are to recommend policies, provide guidelines, and evaluate the performance of VA optometry programs. He said, like other program directors within VA Central Office, he has no "real power" and can make no line decisions. Accordingly, the director's ability to improve the role of optometrists and develop optometry programs in VA is limited.

As of March 1978, VA had not established program guidelines for the operations of its optometric services. In our opinion, such guidelines are needed to define the optometrists' duties and responsibilities, and specifically how optometrists and ophthalmologists would interact in a VA health care setting. Currently, VA hospitals with optometric services operate under program guidelines developed locally or they have no guidelines. As a result, the scope of eye care programs at these hospitals is inconsistent.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

There is a need for VA to expand its eye/vision care services for eligible veterans seeking medical care and treatment at VA medical facilities.

Based on available information, a significant percent of veterans have eye/vision disorders which require some type of care and/or treatment. Under VA's present eye/vision care program, many of these veterans may not be receiving needed care and treatment.

One alternative in meeting the eye/vision care needs of veterans would be to expand VA's use of optometrists. These individuals are specifically trained to examine eyes to determine eye/vision abnormalities, prescribe corrective lenses, and refer those patients with suspected disease or injury to physicians. Experience at the Birmingham and other VA medical facilities, as well as other health care systems, has demonstrated that the use of optometrists has been beneficial to patient care.

In comparison to other health care systems, VA employs few optometrists even though recent legislation improved its ability to recruit and retain optometrists. Furthermore, VA participates in few optometric training programs, although legislation authorized it to participate in such programs in cooperation with schools and colleges of optometry.

VA has made an effort to improve its eye/vision care program by employing optometrists and participating in academic affiliations with schools and colleges of optometry. However, VA's efforts have been hindered because of resistance from ophthalmologists, space and/or funding limitations, and lack of adequate direction and planning from VA Central Office.

To date, VA has done little to overcome these problems. VA Central Office has delegated its central management responsibilities to individual hospital and clinic directors. In view of the limited success of expanding optometric programs in these hospitals and clinics, we believe that VA Central Office should assume a more active role to insure that the development of such programs is successful.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator direct the Chief Medical Director to:

- --Determine the adequacy of existing optometrist/ ophthalmologist staffing and eye/vision care programs at each VA medical facility for meeting the needs of veterans seeking care and treatment.
- --Develop eye/vision care programs using both optometrists and ophthalmologists to strengthen those programs considered to be inadequate.
- --Develop guidelines which set forth optimal optometrist/ ophthalmologist staffing levels and the roles and responsibilities of optometrists with emphasis on their interaction with ophthalmologists in VA medical facilities.
- --Increase VA's participation in the education and training of optometrists in cooperation with schools and colleges of optometry.

(40136)

PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

June 15, 1987

The Honorable Alan Cranston, Chairman
Senate Committee on Veterans' Affairs
Russell Senate Office Building, Room 414
Washington, D.C. 20510

ATTENTION: Sandi Isaacson

Dear Senator Cranston:

Per your request, the following information is submitted for the record. This supplemental statement pertains to the Committee's May 21, 1987, hearing on various health care issues as follows:

S.6

SEC.4 - READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES

PVA supports this amendment. The bill would amend Section 612A(g) of title 38, United States Code, postponing for one year, the transition period for the VA's Vet Center program.

Due to the fact that the mandated comprehensive study concerning Vietnam veterans and post-traumatic stress disorder has been significantly delayed, PVA finds this extension of the current transition date wholly warranted. The comprehensive study was designed to enable Congress to make informed decisions about the future of the Vet Center Program. Since 1979, the VA has provided counseling for more than 500,000 veterans and family members in Vet Centers. These centers provide referral service as well as counseling for employment, marital, stress-related and other readjustment problems.

PVA believes, that without the Administrator and the Congress having the necessary documentation relevant to the status of Vietnam-era veterans, any planning or transition of Vet Centers should be delayed. We believe the VA should refrain from moving any "storefront" Vet Centers, transitioning their services to VA medical facilities, until the final results of the study are released and thoroughly reviewed.

PVA is also supportive of this section which would extend readjustment counseling services to Vietnam Veterans and provide eligibility to individuals who served on active duty in the military since Vietnam and who were subject to combat during periods of hostile action in places like Beirut, Grenada, and recently the Persian Gulf.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300
Chartered by the Congress of the United States

SEC.5 - PILOT PROGRAM OF NONINSTITUTIONAL ALTERNATIVES TO INSTITUTIONAL CARE

PVA is supportive of Section 5, which would authorize the Veterans Administration to carry out a pilot program designating five VA medical centers as test sites to conduct management efficiency programs. The provision would give designated medical center directors the flexibility to waive or alter certain laws and regulations governing the management and administration of their centers in order to tailor individual fiscal and mangement policy to site-specific needs. PVA is fully aware of the unique mission and operation of each of the VA's 172 medical centers. Undoubtedly, national regulations governing the administration of a national health care system as diverse as the VA could at times interrupt or hamper the efficient management abilities of an individual medical center director attempting to meet specific changing needs at his or her facility.

We believe the pilot programs could be useful in identifying areas where the proper administrative flexibility could be given to a station director to promote management initiative, improved efficiencies in service and potential cost savings to the VA. In supporting this provision, however, we would caution the Subcommittee to insure that any waiver of regulation granted to a medical center director, and any resulting efficiency, should not be construed at either the local or the central office level as an open invitation to restrict budgets and services to veterans. Any such efficiencies should be made and used for the enhancement of the quality and quantity of care. While this section does specifically address the preservation and protection of the facilities' budget, we believe that the Subcommittee should underscore the point that any localized waiver of national management regulations at 5 of the 172 VA Medical Centers should be closely monitored to avoid any inconsistency with existing health care eligibility requirements and general administrative practices established by law and regulation common to the entire VA medical system.

SEC.10- REPORT ON CERTAIN ACTIVITIES RELATING TO TRAINING IN GERIATRICS OF MEDICAL AND OTHER HEALTH PROFESSIONAL SCHOOLS AFFILIATED WITH THE VETERANS ADMINISTRATION

As stated, this Section mandates that the Veterans Administration furnish a status report on the training in geriatrics of health care personnel to effectively be prepared to treat the expected increased population of aging veterans. PVA supports the Committee's mandate for the VA to provide progress reports on this important phenomena. PVA would also request the Committee's consideration to stipulate VA geriatric research to specifically address the needs and treatment of aging veterans with spinal cord injured and/or disease.

S.105

Introduced by Senator Daniel Inouye, to amend title 38, United States Code, to provide for the payment of incentive special pay to Veterans Administration psychologists who obtain certain board certification in a professional specialty. This section provides for incentive special pay to psychologists who obtain certain board certification. PVA is supportive of this measure as it will also serve as a useful tool for the VA's recruitment and retention of health care personnel. See PVA May 21, 1987, testimony, before the SCVA, page 7, Recruitment and Retention of VA Health Care Personnel.

S.915

Introduced (by request) by Senator Alan Cranston to amend title 38, United States Code, to authorize the Chief Medical Director to waive state licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country. While PVA understands the intention of this measure, we have reservations regarding any measure that would allow the waiver of professional licensure. Many research efforts can or could indirectly involve direct patient care.

S.939

Introduced by Senator Alan Cranston (by request) to amend title 38, United States Code, to improve the administration of veterans' health care benefits and for other purposes. PVA is supportive of the three sections which would amend section 603(a), section 620, and section 624(b) of the title to provide respectively the Veterans Administration with the authority to pay for emergency hospital care for veterans who have been placed in community nursing homes at VA expense; authorizing the Veterans Administration a maximum per diem rate for contract nursing care of 50 percent of the cost of care in a community general hospital in Alaska and Hawaii; and to provide service-connected veterans who are foreign national residing abroad with eligibility for VA health care for their service-incurred disabilities.

S.1062, S.1065, S.1125,S.1136

As it pertains to S.1062, S.1065, S.1125, and S.1136, introduced by Senator Alan Cranston (by request), PVA submits, "NO COMMENT;" as we believe these legislative proposals are matters of internal administration of programs.

S.1065

Introduced by Senator Alan Cranston (by request) to amend title 38, United States Code, to authorize the Administrator of Veterans Affairs to provide on call pay to certain civil service health care personnel. PVA is supportive of this measure as we believe the provision of S.1065 to be fair and equitable, while it also offers a tool for recruitment and retention of health care personnel. Further, this measure will make consistent the methods and payment of "on-call" duty for all health care professionals in the VA. We believe that the authority to provide "on-call" duty in emergency situations is necessary to provide 24 hour medical care to our nation's veterans.

S.1089

Introduced by Senator Alan Cranston (by request) to amend title 38, United States Code, to improve the State Veterans' Home Grant Program. S.1089 would provide two clarifying amendments to the State Veteran Home Program as revised by Public Law 99-576. The laws, enacted last year, revised VA grant award procedures requiring certain prioritization of grant projects for funding purposes effective July 1, 1987. The law, however, did not "grandfather" or provide an exemption from the new criteria for certain projects with long-standing application on file, or interim procedures for the VA to approve these applications. The law also requires the VA to provide funding for grant applications beginning October 1st of the calendar year, based upon a prioritized list established the preceding July 1st. The VA's interpretation of this language precludes the agency from dispensing grants during this three-month period this year. This bill would relieve the VA of this restriction as well as grant the Administrator the authority to delegate funds to a state for a state home grant application which is high on the priority list, but which may not have been completely processed through the required state approval procedures. PVA supports these needed improvements which will help facilitate and speed the administration of the State Veteran Home Program.

In response to your request, this concludes our comments. If we can be of further assistance, please do not hesitate to call.

Sincerely yours,

Frank R. DeGeorge

Frank R. DeGeorge
Associate Legislative Director

FRD/df

AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES

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Marjorie B. Wheeler, RN, MS
Suzanne K. White, RN, MN, CCRN
Gayle R. Whitman, MSN, RN, CCRN

Executive Director
Sandra J. Edson

June 3, 1987

Alan Cranston, Chairman
Senate Committee on Veteran's Affairs
Russell Senate Office Bldg., Room 414
Washington, DC 20510

Dear Senator Cranston:

The American Association of Critical-Care Nurses (AACN) would like to take this opportunity to submit Post Hearing Testimony on Veteran's Health and Health Personnel Issues. The American Association of Critical-Care Nurses, on behalf of it's 57,000 members, is very interested in assuring that quality nursing and health care is provided to the nation's veterans.

AACN is acutely aware of the current shortage of registered nurses in hospitals nationwide, particularly in critical care units. Consequently, the Association is involved in numerous efforts to recruit nurses into the critical care specialty.

Current staffing inadequacies are largely due to difficulties in the recruitment and retention of capable qualified professional nurses. The overall nursing shortage, increased patient acuity, and earlier discharges, have resulted in a significant increase in the workload per registered nurse.

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Impact of Nursing Shortage

For example, nurses who work in settings where all allocated registered nurse positions cannot be filled are forced to change the way they provide care. They are required to take on an accelerated pace of activities in an effort to stay on top of everything. One alteration in their work style often leads to another; as their workload increases they must set new priorities for the nursing care they give. When nurses have an unrealistic workload, the margin for error increases. Patients may not be monitored as frequently or as thoroughly. Gradual changes signaling the onset of more serious problems may not be immediately recognized. Crisis situations occur that might have been prevented. In addition, psychological care, teaching, emotional support and counseling are often omitted.

Providing less than optimal patient care often results in low morale and a sense of dissatisfaction. When vacancies exist, hospitals frequently resort to mandating that nurses work extra hours, i.e., double shifts and on their assigned days off. Ultimately these nurses become exhausted, disillusioned and burned out. Because sufficient adjustments in pay and benefits have not occurred to compensate for the increased workload and the highly sophisticated and highly technical nursing care required, retention and recruitment, especially in specialized practice areas is becoming increasingly more difficult.

We understand that VA hospitals are over 8,000 nurses below their own staffing guidelines for nursing personnel. The result is critical care units with increased patient per nurse ratios, and intensive care units that are staffed with outside agency nurses who make considerably more per hour than VA nurses. These situations have a tendency to lower morale and affect the ability of hospitals to retain staff. We recognize that nurse retention may be difficult under these circumstances and are pleased that the VA is taking positive steps to address the nursing shortage. We would like to take this opportunity to address some of the bills that have been introduced that address the nursing shortage in the VA.

S. 713

S.713, introduced by Senator Murkowski, would amend Title 38 to facilitate recruitment of RNs by the V.A. by providing a bonus of up to $20,000 to nurses who agree to the provisions of employment. We understand that the bonus could be offered for nurse recruitment as well as for retention.

AACN agrees with American Nurses Association testimony that bonuses are short term solutions. They attract people initially, but if the problems of inadequate staffing and job dissatisfaction persist, the recipient leaves after fulfilling her obligation. Inasmuch as this bonus is discretionary, we questions whether it will be generously offered. Effective implementation of the proposed bonus program may be hampered by the same difficulties exhibited in the existing V.A.

special pay programs. Determination of significant problems in recruitment and retention of registered nurses in specific geographic location and professional specialties could be so time consuming as to be effectively non-feasible.

We do not believe that the bonus plan is a viable long term option for retention of tenured VA nurses, and fear that it will create morale problems.

AACN does, however, support continued and increased funding for the VA Health Scholarship Program.

Today's patients and their families present increasingly complex problems and have multiple care requirements. These trends are likely to intensify. Therefore, the knowledge and skills of the nurse must be at a level sufficient to meet the changing and complex demands of patient care.

BSN and MSN programs will offer this global perspective with an emphasis on independent decision making, critical thinking skills, health promotion, and health care in a family setting.

AACN therefore urges that serious consideration be given to not only continued but increased funding for the VA Health Scholarship Program.

Special Pay

We support ANA's position that if junior grade nurses at 92 hospitals receive special pay, which places them at the top scale, perhaps a better strategy would be to delete junior grade. Entry positions could be restructured at the associate level to accommodate a new starting salary for nurses.

S. 1065

S. 1065 authorizes "on call" pay to certain civil service health care personnel. AACN supports the VA's efforts to assure adequate staffing for medical emergencies. Title 38 presently authorizes "on call" pay to RNs, and this bill further removes inconsistencies between Title 38 and 5 employees where duty requirements are similar. The existing provision was inequitable as to physical confinement for Title 5 employees and penalized professional nurses by paying them less for "on call" than "standby" Title 5 employees.

S. 1195

AACN is pleased that S. 1195 proposes several options that organized nursing has long advocated. As we have stated, AACN endorses the VA Health Scholarship Program. We also support ANA's recommendation that the obligated service be a minimum of two years, with one additional year for each year of support. Payback should not be viewed as so burdensome that it inhibits enrollment in the program. Although we recognize the budget concerns which necessitate priority for senior year student applicants, disciplines other than nursing are not so restricted. Additionally, restriction of scholarships to senior year students would significantly reduce the pool of qualifying applicants.

Although the bill for the first time authorizes tuition reimbursement, we are concerned that it will not accomplish what it is expected to do as long as it is patterned after the existing scholarship program.

We believe any nurse who meets the qualification standards for tuition reimbursement should be eligible. The proposed application of employment evaluation criteria and external committee determination requires excessive administrative involvement for a tuition reimbursement program. We recognize that those unfamiliar with employment tuition reimbursement plans may overestimate the costs by envisioning the VA's total nursing force requesting such reimbursement. Estimates indicate that only 10% of the eligible nurses will avail themselves of a tuition reimbursement program. We suggest the VA make a reasonable cost estimate for the program, and request sufficient funds to realistically compete with the private sector. Too restrictive an application process for the tuition reimbursement program will render it ineffective. We, therefore, urge the committee to reconsider the program, and designate it as an entitlement.

AACN endorses the provision for Saturday and Sunday premium pay. Many hospitals in the private sector offer additional pay for weekend staffing. Such pay is especially important when nurses only receive one weekend off out of three. The VA is already at a disadvantage in that the private sector provides every other weekend off for full time nurses. Weekends increase the nurse's responsibility because of decreased staffing in other hospital departments and changes in staffing schedules. It is illogical and inequitable to offer less pay for weekend duty under those circumstances

In closing, AACN reiterates its commitment to assuring quality nursing care to our nation's veterans and thanks you for the opportunity to present AACN's concerns and recommendations.

Sincerely,

Sandi Dunbar

Sandi Dunbar, RN, DSN
President

SD:sf

American
Psychological
Association

June 12, 1987

The Honorable Alan Cranston, Chairman
Veterans Affairs Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing on behalf of the 87,000 members of the American Psychological Association (APA) regarding legislation now being considered by the Senate Committee on Veterans' Affairs. At the present time, there are approximately 1300 doctoral-level psychologists within the VA's Department of Medicine and Surgery (DM&S), and APA is pleased to have this opportunity to offer comments on legislation that relates to the health care of our nation's veterans. I would like to request that this statement be entered into the record of the May 21, 1987, legislative hearing on various bills relating to veterans' health care.

Mr. Chairman, although many of the legislative measures before your Committee affect the psychologists in the VA's DM&S, I will limit our comments to four bills: S. 6, S. 91, S. 105, and S. 915.

Your bill S. 6, the Veterans' Health Care Improvement Act of 1987, is a comprehensive measure, and APA supports many aspects of this legislation. We would like to focus our comments to Section 8 of this bill. This section would amend section 4103 of title 38, United States Code, to increase the VA Administrator's flexibility for making appointments to certain positions within the DM&S Office of the Chief Medical Director (CMD). This section would enable certain non-physician health care professionals, defined in Section 4105 of title 38 of the U.S. Code -- including psychologists, dentists, podiatrists, nurses, optometrists, and pharmacists -- to be eligible to serve as Associate CMD and as Assistant CMD. Section 8 of S. 6 would also require all individuals appointed to those positions in the Office of the CMD to be qualified in the administration of health services. APA believes that these professionals should be eligible to hold positions in the CMD's Office and that the VA will be better equipped to serve the health care needs of veterans through the greater flexibility afforded to the VA Administrator through this provision. Accordingly, APA supports the adoption of Section 8 of S. 6.

In a similar manner, S. 91, which was introduced by Senator Inouye, would qualify psychologists, as well as the other health care professionals noted above, for the position of Chief Medical Director (CMD), in addition to the other positions of Deputy CMD, and Associate Deputy CMD specified in Sec. 8 of S. 6. APA is also supportive of the passage of this measure.

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Washington, D.C. 20036
(202) 955-7600

S. 105, another bill introduced by Senator Inouye, would provide a special incentive pay for certain psychologists who have attained their board-certification. Specifically, S. 105 would award this special pay to psychologists who have received their diplomas in Clinical or Counseling Psychology from the American Board of Professional Psychology. S. 105 would also give the VA Administrator the authority to award the special pay to psychologists who have attained an advanced degree, such as a masters degree in public health, if determined to be in the best interest of the VA. Currently, title 38, United States Code, provides for a special pay program of $2,500 annually for full-time physicians for attaining board certification in a medical specialty related to the medical services they provide in the Veterans Administration. Passage of S. 105 would grant this same specialty pay to psychologists.

Mr. Chairman, in the Administration's testimony before your Committee on May 21st, VA Medical Director Dr. John Gronvall said that the VA estimates the cost of the special pay authorized by S. 105 at $2.22 million in the first fiscal year, and $11.1 million over the next five fiscal years. APA must take serious objection to the use of these figures and would question the VA on how they arrived at the cost estimates. Using the VA's own numbers for psychologist diplomas from the American Board of Professional Psychology (there are currently only 84 psychologists with clinical diplomas and 15 with counseling diplomas), it is clear that if S. 105 were enacted it would cost only $272,500 in FY 87.

In 1984, Congress granted the Administrator -- through the Veterans' Health Care Amendments, P.L. 98-528 -- the discretionary authority to award psychologists this "board-certification" special pay. However, the VA has yet to implement this provision. APA believes that passage of S. 105, which would mandate the award of this pay, will enable the VA to attract and retain board-certified psychologists and, as such, will reward those psychologists most highly qualified and would promote the delivery of quality health care in VA hospitals and treatment facilities.

S. 915 is aimed at promoting the VA's research and education programs. It proposes to amend section 4114 of title 38, United States Code, by deleting the state licensure criterion for several health professionals, such as physical therapists, and practical, vocational and registered nurses, for certain research or academic assignments in which there would be no responsibility for patient care. You will recall that the state licensure requirement was already deleted for psychologists in research or academic posts during the 99th Congress. Last year, the Senate-passed version of the 1986 Veterans' Health Care Improvement Act (P.L. 99-576) also deleted the additional requirement of completion of an internship for psychologists, but was omitted in the final version of that legislation. APA would like to request that S. 915 be amended to delete this internship requirement for psychologists involved in research programs or those holding academic positions, as many qualified to do so may not have completed a clinical internship.

APA would like to extend our gratitude to you, Mr. Chairman, as well as to the other members of the Committee, for your efforts in addressing these important issues. We would like to offer our assistance in preparing the proposed amendment to S. 915 which would enable a greater variety of psychological expertise in the conduct of research. Please feel free to call our Health Policy Officer, Pamela West, in the APA Office of Professional Practice. She can be reached at 955-7618.

Again, Mr. Chairman, APA appreciates this opportunity to express our concerns and recommendations.

Sincerely,

Leonard D. Goodstein

Leonard D. Goodstein, Ph.D.
Executive Officer

LDG/prw

cc: Members of Senate Committee
on Veterans' Affairs

NAVAP
NATIONAL ASSOCIATION OF VA PHYSICIANS
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XII Cyril Barnert, M.D
Los Angeles, CA

June 15, 1987

Senator Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Senator Cranston:

I want to express my appreciation for being allowed to testify on behalf of the National Association of VA Physicians (NAVAP) at the Committee's hearings on May 21st. I am also please to further clarify our position on S.713, S.1062, S.1136, and S.1195 as you requested in your letter of May 28, 1987.

With reference to S.713, NAVAP is fully supportive of the creation of variable incentive bonuses to registered nurses. As I testified, the nursing shortage is so acute in some facilities that full wards are being closed. Although, this measure can be only a short term solution, the situation is severe enough to warrant it. We are very impressed with the solutions suggested in the "Veterans Administration Health Care Personnel Act of 1987", (S.1195) especially the sections on tuition reimbursement for nurses, and feel that those are at least a first attempt at a long range solution.

We have great concerns regarding S.1062. Physicians should be adequately reviewed during their probationary period by mechanisms presently in place and we can use no justification for the addition of a board to further review and I make recommendations that can be overridden by the Chief Medical Director.

We must be adamantly opposed to S.1136 which would limit the review by disciplinary boards to those actions resulting in removal, suspension of more than 14 days or demotions involving loss of pay or grade. In addition, this bill would allow the Chief Medical Director to delegate the authority to establish the board back to the facility which had instituted the adverse action. Too often physicians are disciplined by the removal of clinical privileges, to most professionals a punishment more severe than a suspension, and yet these would not be subject to review. I testified very strongly against this bill in both my oral and written testimony and we remain totally against it.

I should be noted, though, that the system for review of disciplinary actions is highly inadequate and rarely protects professionals, both full-time and especially part-time, from capricious and vindictive actions by their superiors. NAVAP would encourage and applaud any attention that the Committee could address to this matter.

I have already referred to S.1195 above. NAVAP strongly endorses the Educational Assistance Program (Section 5) of this bill and sincerely hopes it will help in the recruitment and retention of professional employees. We also fully endorse Section 3 which would provide premium pay to nurses for Saturday work. NAVAP has no position on Section 2 or Section 4.

Again, let me thank you for the opportunity to testify and respond to your questions. If we can be of any further assistance, please feel free to contact us.

Sincerely,
Peter Hawley, M.D./B
Peter Hawley, M.D.
President

TESTIMONY OF SENATOR DANIEL K. INOUYE FOR THE VETERANS AFFAIRS COMMITTEE RELATING TO S. 105

Mr. Chairman, I thank you for the opportunity to submit testimony in support of S. 105 which would provide psychologists currently employed by the Veterans Administration with the same pay bonus that their physician colleagues receive upon attaining board certification. More specifically, S. 105 would authorize the payment of incentive special pay to those psychologists awarded board certification in clinical or counseling psychology by the American Board of Professional Psychology, or who have received an additional advanced degree which the Administrator determines to be in the best interest of the Veterans Administration.

Section 4118 of Title 38 of the United States Code establishes a special pay program for physicians in the Department of Medicine and Surgery. There are two primary components to this special pay program. First, upon a determination that there are difficulties in recruiting and/or retaining physicians in a particular medical specialty, the award of special pay is authorized as an incentive to increase the number of physicians in the Department of Medicine and Surgery. This special payment varies from $4,000 - $15,500 per annum for full-time physicians, and between $3,000 and $12,375 per annum for part-time physicians.

Second, section 4118 authorizes a separate special pay program of $2,500 per annum for full-time physicians and $1,875 per annum for part-timers as a reward for attaining board certification in a medical specialty related to the medical services provided by the Veterans Administration. It is clear that the two special pay programs for the physicians address two separate goals: (1) to recruit and retain physicians, and (2) to elevate the standard of medical care through providing physicians with an incentive special pay award for those who attain board certification.

My bill, S. 105, addresses the second justification for awarding special pay. Accordingly, the issue of whether there is a shortage of psychologists in the Veterans Administration is moot. My primary concern centers upon providing America's veterans and their beneficiaries with the highest quality of psychological services. One major step in that direction would be to offer incentive payments for board certification to elevate the caliber of psychologists on the Veterans Administration's health care staff.

Upon being posed the question of whether providing such incentive payments would improve the Veterans Administration's ability to retain qualified psychologists, Dr. John A. Gronvall, Chief Medical Director for the Veterans Administration, answered in the affirmative. However, he further stated that the Veterans Administration is still studying the "most cost-effective results for the desired outcome of encouraging present [psychological] staff to pursue [board certification]." Dr. Gronvall's statement exemplifies the discrepancy between the róle of the physician and that of the psychologist. My bill will rectify this disparity.

When Congress authorized special pay for those physicians who received board certification, it either did no cost-benefit analysis or determined that $2,500 was cost-justified. Hence, the Veterans Administration is seemingly suggesting that the services offered by the psychologists are less important such that a different, more stringent, standard be imposed upon this profession to determine whether the payment of $2,500, the same as that allocated for physicians, is cost-effective. This disparity is counterproductive in the Veterans Administration's ability to reach its goal of providing high quality health care in the diverse facets of healing the body and the mind. As William McDougall, so eloquently phrased it, in "An Introduction to Social Psychology," "Psychologists must cease to be content with the sterile and narrow conception of their science as the science of consciousness, and must boldly assert its claim to be the positive science of mind in all its aspects, ... or the positive science of conduct or behavior."

Accordingly, the time has come to mandate equality in the offering of pay incentives amongst these worthy professions. Although the Veterans Health Care Amendments of 1984, P.L. 98-528, provided the Administrator with the authority to award such pay bonuses as he or she deemed appropriate, the Administrator has not acted upon its grant of discretionary authority. Hence, S. 105 mandates that the Administrator award special pay incentives to those psychologists who attain board certification, or who receive an additional advanced degree in a field determined in the Veterans Administration's best interest.

In conclusion, the Veterans Administration should send out a consistent signal which encourages both the healers of the body and of the mind to excel in their respective professions with the ultimate goal being the improvement of the quality of health care -- medical and psychological -- provided to America's veterans.

STATEMENT OF EARL E. JONES
COMMISSIONER
FEDERAL PROPERTY RESOURCES SERVICE
GENERAL SERVICES ADMINISTRATION
SUBMITTED TO
THE SENATE COMMITTEE ON VETERANS AFFAIRS
IN WASHINGTON, D.C.
MAY 21, 1987

Mr. Chairman and Members of the Committee:

I am Earl E. Jones, Commissioner of the Federal Property Resources Service, General Services Administration (GSA), and I would like to submit for the record the views of GSA on S. 6, a bill cited as the "Veterans' Health Care Improvement Act of 1987."

GSA has no comment on the need for or overall merit of the bill as it relates to improving the delivery of veteran health care services; however, we would like to comment on the real property provisions contained in section 9 of the bill. Section 9, if enacted, would prohibit the Administrator of Veterans' Affairs from declaring as excess or taking any action to dispose of specific land and improvements located at the Veterans Administration (VA) Medical Centers in West Los Angeles (approximately 109 acres) and Sepulveda (approximately 46 acres) in the State of California. The section would also repeal section 234 of Public Law 99-576, which prohibits the same actions until January 1, 1988, and would place a permanent sanction against disposal of the property.

GSA strongly opposes section 9 of the bill. The property described in the section is currently under the control and custody of VA and has not been reported to GSA for further Federal utilization or disposal. Last February VA notified

Congress of its intent to declare the property excess. VA's notice to Congress was subsequently modified to reflect the views of the new VA Administrator so that less property would be excessed.

It was the intent of Congress in enacting the Federal Property and Administrative Services Act of 1949, as amended (Property Act) to establish an overall system for the economic and efficient use and disposal of the Government's real property. We believe that enactment of section 9 of S. 6 would contravene provisions of the Property Act which vest authority in agency heads to determine whether real property under their control is excess to agency needs. Such contravention would further frustrate the clear intent of Congress as expressed in general law that unneeded property be reported to GSA for disposition. These statutory requirements which represent longstanding Congressional policy should continue to be followed in this case since the VA has determined that the property is not needed for its purposes.

Under normal procedures when property is reported as excess to the needs of another Federal agency, GSA first ascertains whether a Federal need exists for its use. In the absence of such need, based on its highest and best use, the property is made available to local governments by negotiated sale or at no cost for public benefit purposes such as health, education, park and recreation. If the property is not acquired by a local government, it is then offered for public sale. Section 9 would violate these existing statutorily based procedures and would force the Federal Government to retain ownership of unneeded real property with the attendant cost associated with such retention.

In addition, Administration efforts to improve the management of the Government's real property assets by Federal agencies through issuance of Executive Order 12512 on April 29, 1985, have vested GSA and the Office of Management and Budget (OMB) with responsibility to ensure that this mandate is implemented by the landholding agencies. The Executive order broadened agency real property management responsibilities and expanded accountability for the release of unneeded property.

In the implementation of the President's program to improve property management, GSA's responsibility is to identify and to recommend the release of unused property and, thereafter, to provide for its disposition, by sale or otherwise. In this way, the Government obviates the economic burden of retaining such property and local communities benefit by placing the property in productive use and returning it to the tax rolls.

Under predecessor executive orders, as well as Executive Order 12512, GSA has for many years identified unused and underutilized property through utilization surveys. The two properties in question have been the subject of such surveys in the past. The first surveys were conducted in 1970 and portions were identified as unused at that time. These properties were surveyed again in 1983 and updated in 1985 with the same conclusion and recommendations for excessing.

On June 6, 1986, the new VA Administrator notified Congress of his intent to modify the Agency's original report and to declare as excess to VA needs approximately 80 acres at West Los Angeles and 31.8 acres at Sepulveda. The excessing recommendations have been fully assessed by VA, personally reviewed by the Administrator, and meet the criteria of 38 U.S.C. section 5022. The land proposed for excess is not needed now or for the foreseeable future by the VA to fulfill its mission. We believe VA's decision to report this property excess reflects sound real property management. Based on general local real estate market trends and other information received from knowledgeable sources, such as local tax assessment offices, GSA estimates the value of the properties covered exceed $100 million.

Enactment of section 9 would preclude use of the property by other Federal agencies and the possible consideration of other meritorious uses by potential donees and purchasers of Federal surplus real property as provided under the Property Act. GSA and VA agree that this property is unneeded to fulfill VA's current or future requirements. The Government should not retain unneeded assets in its inventory frustrating their use and development. The release of unneeded properties such as this one can produce revenue. In fact, considering the value of the property involved, we believe enactment of this provision would significantly impact our ability to meet our sales receipts targets as reflected in the President's budget.

In summary, we see no justification for legislation further exempting this property from the provisions of the Property

Act, thereby forcing the Federal Government to retain ownership of unneeded real property. Such a measure is contrary to the Administration's initiative emphasizing the need for improved management of Federal real property and would significantly impact on the budget. Disposition of the property, in accordance with the existing law, would best serve the interests of the Government and the public. Therefore, we urge the deletion of section 9 from the bill.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

June 11, 1987

The Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Mr. Chairman:

This is written to supply you with the VFW's position on several measures which were not covered at the Senate Veterans' Affairs Committee's May 21st hearing concerning various health care issues.

S. 105 is a bill to amend chapter 73 of title 38 USC to authorize the Administrator to provide incentive pay to certain psychologists who meet specific criteria and who would obligate themselves to complete a specified period of service in the Veterans Administration's Department of Medicine and Surgery. The VFW would support this proposal inasmuch as psychologists are an essential component in supplying veterans with a complete continuum of health care and that similar incentives are currently available to other health care professionals.

S. 1089 would remedy what is essentially a technical flaw in P.L. 99-576 which significantly revised the law governing the award of grants under the State Veterans' Home Program. As a consequence of this law, effective July 1, 1987, the current State Home Grant Award procedures would have been replaced with procedures requiring prioritization of grant projects. By eliminating the provisions of law under which VA currently approves applications, the law inadvertantly prohibits the VA from using these procedures after July 30, 1987. Consequently the new law provides no authority for awarding grants during the period of July 1 to October 1, 1987. S. 1089 would establish an interim mechanism that would allow the VA to award grants during this period if the Administrator had previously notified the state submitting the grant application of the availability of federal funds for the grant. This bill would also provide an amendment to permit the Administrator to approve and obligate funds for State Home Grants for a project which is high enough on the priority list to be notified of the availability of federal funds even though the state has not met all requirements for the grant. This would eliminate the situation where the VA would be unable to approve a grant in the next fiscal year under the new priority system even though a state had been notified that funds were available in the previous fiscal year and had incurred significant costs in reliance on that notice. This would also prevent the VA from acquiring a significant non-obligated balance of such funds at the end of the year. The VFW perceives S. 1089 as eliminating what are essentially technical disparities which would serve to strengthen and improve the Program and we therefore support this bill's enactment into law.

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

S. 1125 would authorize modifications of the structure of the Office of Chief Medical Director and provide authority for other administrative procedures. With one exception, the VFW is in basic support of this bill as is articulated in our written statement at the May 21st Senate hearing addressing the same measure as introduced in the House, H.R. 2010. This is to be found on page 13 of our statement.

S. 1136 would amend 38 USC 4110 to limit the function of disciplinary boards appointed by the Chief Medical Director to only ruling on more severe personnel actions and to allow for the delegation of authority of the Chief Medical Director in certain situations with respect to certain non-probationary full-time health care professionals. As articulated on page 12 of our written statement addressing the same legislative proposal as introduced in the House, H.R. 2009, the VFW considers this legislation a liberalization of administrative policy and has no objection to its enactment.

S. 1195 would first move pharmacists and occupational therapists into a title 38/5 "hybrid" category, thereby providing the VA with needed flexibility in appointment and pay matters. Second, open the Health Professional Scholarship Program to physical therapists and other individuals who provide direct patient care services or who provide services incident to such care. Third, lengthen the period of obligated service under the Scholarship Program from one year for every year of support to two years for every year of support and provide priority to nurses seeking a fourth year of baccalaureate training. Fourth, provide for nurses who work on Saturdays the same premium pay currently applicable to the Sunday work period. Fifth, establish a tuition reimbursement program for full-time nursing personnel as well as for certain other full-time health care personnel who are performing in a superior fashion in academic courses leading toward completion of a nursing or certain other appropriate degree granting fields. Sixth, and last, require that the Chiefs of Nursing Service or their designees be members of the VA health care facility's policymaking and fiscal committees. Inasmuch as this bill would contribute toward assuring quality health care for our nation's veterans at VA facilities, the VFW supports S. 1195.

Thank you for providing us with this additional opportunity to set forth our position on these various measures of concern to this nation's veterans. If you have any other concerns or questions in this regard, please feel free to contact this office, and with best wishes and kind regards I am

Sincerely,

James N. Magill

JAMES N. MAGILL, Director
NATIONAL LEGISLATIVE SERVICE

STATEMENT OF
DAVID J. PASSAMANECK
NATIONAL LEGISLATIVE DIRECTOR

AMVETS

BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

ON

S. 6, 216, 631, 713, 894, 105, 915, 939, 1062, 1063, 1065,
1089, 1125 AND 1136

21 MAY 1987

Mr. Chairman, the American Veterans of World War II, Korea and Vietnam (AMVETS) is pleased to present our views regarding:

1. S. 6, which includes various provisions designed to maintain and improve VA health-care programs.

2. Legislation to address problems in the recruitment and retention of VA health-care professionals.

3. S. 216, which is substantively identical to section 7 of S. 6.

4. S. 631, requiring the standardization of procedures for the procurement of medical and pharmaceutical supplies, S. 713, authorizing payment of a bonus to nurses working in selected VA medical facilities, and S. 894, authorizing the Administrator to furnish certain hospital services to veterans not living in the United States.

5. S. 105, which provides for incentive special pay to psychologists who obtain certain board certification.

6. S. 915, S. 939, S. 1062, S. 1063, S. 1065, S. 1089, S. 1125, and S. 1136, all of which were introduced at the request of the Administration.

S. 6 would provide a basis for a 1-year extension--from October 1, 1987, until October 1, 1988--of the date by which the VA's readjustment counseling program for Vietnam-era veterans is to begin a 2-year transition from being a program providing counseling services primarily through Vet Centers, which are located apart from the VA's general medical facilities, to being a program providing such services primarily through the VA's general medical facilities (section 4(b)); require the Administrator to conduct a 4-year pilot program through not less than 5 nor more than 10 demonstration projects where veterans eligible for and otherwise in need of VA institutional care would instead receive care, including health-related services from non-VA entities, in noninstitutional settings (section 5); increase the rates of per diem payments to State veterans' homes for eligible veterans; provide eligibility for VA readjustment counseling to (1) Armed Forces activity duty personnel who served during the Vietnam era, and (2) persons who served in the Armed Forces after the Vietnam era in combat situations; provide for a revision of the statutory framework of the Office of the VA's Chief Medical Director so as to establish a second Associate Deputy Chief Medical Director position and to authorize the appointment of certain health-care professionals other than physicians to various positions in that office; provide authority for the VA to furnish services to a service-connected veteran or the spouse of a service-connected veteran to achieve pregnancy, for example through artificial insemination or in vitro fertilization, in cases in which a veteran's service-connected disability impairs procreative ability; revise eligibility for VA domiciliary care so as to reflect more accurately the VA's current philosophy and practice in furnishing that type of care; eliminate the Administrator's authority to restrict eligibility for VA health-care benefits; prohibit the VA from accessing certain lands located in southern California; set forth findings of Congress regarding the need to prepare for the impact of the aging of the United States population and of the importance of the Veterans' Administration's playing a leadership role in that regard, particularly with reference to increasing the efforts by medical and other health-professional schools affiliated with the VA in training professionals to care for older patients and in research into the aging process and diseases associated with aging, and require a one-time report from the Administrator, due not later than March 1, 1988, on the VA's activities, and the success of those activities, to promote such increased efforts by affiliated schools. Section

4(b) of the bill would amend Title 38, U.S.C., to extend the transition period for the VA's Vet Center program and in effect call a halt to relocation of the nine centers now scheduled to be colocated with medical centers. Of the nine centers, two transitions are going well; however, four are proceeding badly and three centers are proceeding poorly. There is ample evidence for this transition, at this time being reevaluated. Further, as you may be aware, the Senate recently passed a measure which would delay the transition of the centers. AMVETS urges swift action on this provision not only because the transition schedule is going badly, but also because at least three centers face end of lease agreements in June. This contingency worsens a bad situation threatening program disruption and uncertainty.

AMVETS enthusiastically subscribes to the expansion of eligibility for readjustment counseling services set forth in section 4(a) of the bill, to include active duty Vietnam veterans and certain post-Vietnam veterans, as completely consistent with the eligibility criteria for membership in AMVETS.

AMVETS is also pleased to support Section 5 of S.6, which would establish a pilot program of noninstitutional alternatives to institutional care. This measure should provide an effective approach to the incipient burden of caring for sharply increasing numbers of aging veterans.

Section 2 of the bill, to provide services to overcome service-connected disability affecting procreation is a humane and necessary addition to the health care authority of the VA.

The increase in per diem payments to state veterans' homes is a vital adjunct to the VA's overall efforts, both now and in the years ahead, to meet the health-care needs of older veterans. The clarification of eligibility for domiciliary care in section 3 of the bill is long overdue.

Section 6, which would eliminate a dangerous vestige of the Franklin Roosevelt administration anti-veteran Economy Act of 1933, allowing the Administrator of Veterans Affairs to, in effect, curtail eligibility for health care as provided in Chapter 17 of Title 38, should be enacted, despite the VA's historical reluctance to invoke its provisions.

AMVETS opposes enactment of section 10 of S.6, preventing the VA from declaring certain lands in California as excess to their needs. We have traditionally demurred to legislation which we believe exceeds the legitimate constitutional role of Congress and seeks to micro-manage the detailed administrative operations of the VA. Section 10, in our view, falls in this category.

Although we certainly support a maximum commitment of resources within the VA medical system for meeting the challenge of treating the aging veteran population, we would prefer that those resources be devoted to research and improved delivery of medical services, rather than to lengthy and burdensome progress reports to Congress, such as is required by section 10 of S.6. This provision also imposes an unwarranted degree of micro-management on the agency.

AMVETS is also pleased to support enactment of S.631, S.713, S. 894, and S.105, S.915, as welcome improvements in the operation of the VA Department of Medicine and Surgery.

We prefer not to take a position on S. 1062, S. 1125, S. 1136, S. 1065, S. 1063 and S. 1089, technical amendatory legislation introduced at the request of the VA.

UNIVERSITY OF CALIFORNIA, LOS ANGELES **UCLA**

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OFFICE OF THE CHANCELLOR
LOS ANGELES, CALIFORNIA 90024

June 15, 1987

The Honorable Alan Cranston
Committee on Veterans' Affairs
SR414 Russell Senate Office Building
Washington, D.C. 20501

Dear Senator Cranston:

UCLA is deeply concerned about the current initiative by the government to divest itself of some of the property at the Veterans Administration in West Los Angeles. On December 29, 1986, I wrote you regarding UCLA's long-standing relationship with the VA (see attached letter). I want to take this opportunity to reaffirm UCLA's commitment to work with the VA in developing plans and programs that would contribute to the care of veterans.

UCLA's campus architect has had an initial meeting with the VA staff to discuss the process for reviewing the overall programmatic use of the VA land and the long term proposed plans of expansion of facilities for the veterans. It was mutually agreed that beginning in July, UCLA's land design experts will begin working with the VA staff on a regular basis in an effort to define a long term land use plan. We believe that the future needs of the veterans will necessitate the use of this strategically located property which is being considered "surplus."

UCLA hopes that the government will reconsider its current initiative and hold onto the property, even if it is sparsely used at this moment, because tremendously important non-commercial uses consistent with the land's present commitment are in the process of being developed. Please let me know if I can help in resolving this matter.

Sincerely,

Elwin V Svenson

Elwin V. Svenson
Vice Chancellor-
Institutional Relations

UNIVERSITY OF CALIFORNIA, LOS ANGELES UCLA
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OFFICE OF THE CHANCELLOR
LOS ANGELES, CALIFORNIA 90024

December 29, 1986

Senator Alan Cranston
Committee on Veterans' Affairs
SR414 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

I thought that you would be interested in receiving the enclosed information regarding UCLA's long-standing relationship with the Veterans' Administration in West Los Angeles. This compilation of material will provide you with a complete background and overview of UCLA's past and present work with the VA.

In brief, UCLA's affiliation with the VA began in 1947 at the Wadsworth Hospital in West Los Angeles. UCLA's contracts cover all medical/surgical and psychiatric services provided by the VA, and include the Schools of Nursing, Public Health, and Dentistry. The UCLA School of Dentistry is currently working with the VA to provide staff for small on-site dental clinics at the West Los Angeles and Sepulveda facilities. The UCLA School of Nursing's Geriatric Nurse Practitioner program provides services in facilities at VA/Sepulveda, and its graduates are a primary source of staffing for the VA's domiciliary care beds at Sepulveda.

Under a ten-year cost-reimbursement contract for approximately $15.8 million with the National Cancer Institute, UCLA undertook to acquire a high linear energy transfer neutron generator ("cyclotron") costing approximately $4.5 million; construct facilities costing $3.6 million; conduct field tests and initiate clinical trials for a potential new form of cancer radiation therapy. The Clinical Neutron Therapy Research Facility is adjacent to the Wadsworth Hospital. Delivery and installation of the cyclotron was performed by UCLA employees and the UCLA Medical Center provided financing of $250,000 to help with final equipment fabrication problems stemming from the bankruptcy. You may recall that both you and your staff played an essential role in working out the details of the processing of the NCI contract for which we are all enormously appreciative.

In early 1983, formal agreement was reached with the VA to stage fine arts productions at the "Wadsworth Theater." UCLA Provided $350,000 of structural and cosmetic improvements to the theater as well as offering free tickets for VA patients to all entertainment events. At least 20 tickets per event and frequently more are allocated to VA patients and families in coordination with Recreation Officers at both the VA Wadsworth and Brentwood Divisions.

For more than twenty-five years UCLA has been utilizing facilities in cooperation with the American Legion. In 1980, UCLA made a major rennovation with the concurrence of the VA on the Jackie Robinson Baseball Stadium. One of the main reasons for this project was to provide a spectator sport for veterans. UCLA maintains and protects this land under a three-year renewable lease agreement. The Jackie Robinson Stadium was dedicated on February 7, 1981 and the ceremony was attended by representatives of the VA, UCLA, the Los Angeles Dodgers and many civic groups. On April 27, 1985, a statue of Jackie Robinson was unveiled at the Stadium.

As you may know, in February, 1986, a task force was established to develop long-range plans for the use of the land at the VA Medical Center. Director William Anderson asked me to represent UCLA on the committee along with Associate Dean Esther Hays from the Medical School. This committee in turn has reviewed the many joint programs between UCLA and the VA as well as taking into consideration the long terms needs of the veterans. This was done in order to respond to the proposed possibility of declaring excess some of the land. It was clear to the committee that it was in the best interest of the VA as well as of service to the programmatic needs of UCLA to participate in the joint planning of opportunities and activities to benefit the veterans. Some of the new programs under discussion include: an expansion of the nursing home care program including a mental health component, a specialized adult day care program, the establishment of a pathology reference laboratory, a child care facility, and other programs that the medical staff of the VA and the UCLA faculty are discussing but have not reached a specific recommendation for the committee.

Mr. Anderson and I have talked about the possibility of UCLA providing assistance in reviewing the overall programmatic use of the VA land and the long term proposed plans of expansion of facilities for the veterans. UCLA is reviewing the most efficient use and design of the land on our campus and has offered the services of our land design experts to the VA. Mr. Anderson has been very appreciative of this offer and we look forward to working together on this project.

I hope that this information will be helpful to you. If I can provide you with additional information, please call me at (213) 825-4282.

Sincerely,

Elwin V. Svenson
Vice Chancellor-
Institutional Relations

Medical and Regional
Office Center

White River Jct. VT 05001

Veterans
Administration

May 27, 1987

In Reply Refer To: 405/11

Honorable Alan Cranston
Chairman, Veterans Affairs Committee
Russell Senate Office Building
Washington, DC 20510

Dear Senator Cranston:

I am returning my responses to the questions you gave to me after the hearings.

I wish to thank you and the Committee on behalf of myself and the National Association of VA Chiefs of Staff for the opportunity to express our views on the legislative proposal.

Sincerely,

Howard H. Green

HOWARD H. GREEN, M.D.
Chief of Staff

Enc.

"America is #1—Thanks to our Veterans"

RESPONSES TO QUESTIONS POSED BY THE VETERANS AFFAIRS COMMITTEE

1. Ques: You testified that you do not agree that we should statutorily require the Chief Nurse or Designee to be a member of VA Medical Center Budget and Policy-Making Committees.

1. Ans: I testified that I did not believe that committee memberships should be statutorily defined. I believe that the composition of committees should be the prerogative of the person assigned authority and responsibility for the institution. Committees should not be specifically designed to have members who represent specific interests, but should be designed so that the representatives chosen consider total institutional need. It may be that the Chief Nurse because of personality, style, etc., is not appropriately placed on some committees. This applies equally to any other member of the hospital staff.

A. Ques: Since many VAMCS have still not included representation of nurses on many of these committees, what steps would you recommend be taken administratively to bring about full participation.?

A. Ans: The Veterans' Affairs Committee has the necessary position that concerns about representation of nurses in hospital committees can be presented to the Department of Medicine & Surgery. Since a constructive working relationship between DM&S and the Committee is essential, ground rules can be established which will be acceptable to both parties. It is in the Department's interest to have flexibility; therefore, accommodation to the concerns of Congress is in their best interest.

B. Ques: On what committees at your hospital does the Chief Nurse or Designee sit?

B. Ans: The Chief Nurse or Designees have the following committee assignment at the White River Junction, VT VAM&ROC:

Committee	Representative
Resources (combines Budget, Position Management & Resources	Chief
Clinical Executive Board	Chief
Planning	Chief
Postgraduate Inservice Training	Designee
Equipment	Chief
Infection Control	Designee (co-chair)
Research & Development	Designee (R.N.,Ph.D)
Facilities & Master Planning	Asst. Chief
Disaster & Security Planning	Asst. Chief
ADP Committee	Chief
Therapeutic Agents	Chief
Education	We haven't found a need for this Committee
Dean's Committee	None

Howard H. Green

HOWARD H. GREEN, M.D.
Chief of Staff

American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

Washington Office:
1101 14th Street, N.W.
Suite 200
Washington, D.C. 20005
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Margretta M. Styles, Ed.D., R.N., F.A.A.N.
President

Judith A. Ryan, Ph.D., R.N.
Executive Director

June 12, 1987

Senator Alan Cranston
Chairman
Senate Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
Washington, D.C. 20510-6375

Attention: Ms. Isaacson:

Dear Senator Cranston:

Enclosed are the American Nurses' Association's (ANA) responses to the follow up questions to our testimony at the Committee's May 21, 1987 hearing:

1. ANA believes that the most effective recruitment and retention tool is a higher entry salary for nurses and elimination of salary compression, i.e. many nurses after 10-20 years employment are only earning $10,000 more than the initial starting salary. Bonuses are a short term solution as the employee is attracted initially by the lure of large sums of cash. In addition, once the employee has served the pay back time, she can be enticed by another facility's bonus plan. This raiding occurs especially when working conditions such as inadequate staffing and oppressive workloads remain a problem. There is no incentive for the bonus acquired nurse to remain with a facility. We believe a health care facility's capability of retaining qualified professionals is commensurate with its ability to offer common marketplace benefits, such as weekend premium pay and tuition reimbursement.

2. ANA agrees that in order to encourage people to enter and stay in the nursing profession, the work environment and reward system must be enhanced and salary compression eliminated. We believe that can best be accomplished by better salaries throughout their career and enforcement of professionally designated patient/staff workloads. Additionally, flexible personnel programs such as day care and cafeteria style employee benefit and retirement plans should be explored. The utilization of computers at the ward level for entry result reporting is also an important professional tool for health care providers.

ANA — An Equal Opportunity Employer

3. If the VA had $50 million to spend in any way to improve the VA's ability to recruit and retain nurses, we would recommend spending it on Saturday premium pay and tuition reimbursement for all VA nurses. Money for additional FTEEs especially at intermediate grade would also improve the VA's ability to maintain an adequate qualified complement of staff to assure quality nursing care.

4. The ANA through its 53 constituent state nurses association represents twenty-four collective bargaining units with approximately 5000 registered professional nurses from junior to intermediate grade.

Thank you for the opportunity to respond to the Committee's questions on VA nursing recruitment and retention. If we can be of further assistance, please feel free to contact me.

Sincerely,

Gloria S. Hope, Ph.D., R.N.
Director
Division of Governmental Affairs

GSH/DRR/nch

NOVA
(312) 949-6057
Nurses Organization of the Veterans Administration • 506 E. Hawley St. • Mundelein, Illinois 60060

June 5, 1987

Senate Committee on Veterans' Affairs
Room 414
Russell Senate Office Building
Washington, D.C. 20510

Attention: Sandi Isaacson

Dear Sandi:

Enclosed are the answers to the questions which were submitted to us at the hearing on May 21, 1987.

Please do not hesitate to call upon us to provide additional information.

Sincerely,

E. Elaine Lloyd, R.N.

E. Elaine Lloyd, R.N.
President - NOVA
EEL;pf

cc: C. Morrissey
P. Krull

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RESPONSE TO QUESTIONS

1. a. NOVA concurs with the Agency estimation that approximately 10% of VA nurses would avail themselves of the tuition reimbursement program.

   b. The criterion, with reference to Job Performance, that should be applied to approving applications for the tuition reimbursement program is a satisfactory performance level.

   c. NOVA believes that a morale problem for senior VA nurses would not be created with a tuition reimbursement program if priority was given to the senior VA nurse while at the same time not eliminating newly employed nurses from eligibility. This would allow for the variations that are present from VA station to station or in geographic locales of when and how nurses pursue additional education.

2. If $50 million was available to improve the VA's ability to recruit and retain nurses we would recommend it be distributed as follows:

Saturday Premium Pay	$20 million
A flexible tuition reimbursement program	$10 million

The remainder could be used to help fund special salary rate increases, pay the annual cost-of-living increase for those on special rates, or as a bonus to solve particular local recruitment problems i.e., a bonus for head nurses.

3. a. NOVA agrees that a bonus would need to be paid to all nurses at a particular facility rather than to newly hired nurses or a severe morale problem would arise on top of an existing problem of recruitment and retention.

   b. NOVA believes that in a particular geographic area it is likely that all the VAMCs would be having similar recruitment problems and therefore it would seem unlikely that one would be paying bonuses and the other not.

   c. Spending nurse recruitment and retention dollars only on bonuses for new hires would not be cost effective in our opinion, because it does not address the retention part of the recruitment and retention question. Orientation of new employees is very expensive.

4. NOVA believes that nurses should be present on all VA Budget and Policy making Committees. Participation on these Committees does contribute to enhancing the image of nursing.

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EDWARD J. STYGAR JR., Executive Director, 505 E. Hawley Street
Mundelein, Illinois 60060 (312) 949-8057

Response to Questions - Page -2-

5. Strategies to enhance the image of nursing as a profession:

   - Elevation of the Chief Nurse position in the organization structure to a more senior executive position.

   - Establish Nursing Fellowship programs for post-masters or post-doctoral research in clinical, administrative, and educational pathways.

   - Create the possibilities for collegial exchange and interdisciplinary collaboration through closer scrutiny of the nursing workload in the Veterans Administration. Stress and strain between physicians and nurses will constantly exist when nurses cannot begin to carry out the plans physicians want for their patients because workloads are unreasonable. Studies have shown that mortality rates are lower in those hospital intensive care units where Doctors and Nurses have good collegial relationships.

   - A salary structure that recognizes the worth and contributions of nurses and can respond quickly in the market place.

   - Utilization of the mass media to promote the image of nursing aimed at the pre-school and school age child.

   - Development of a film or video tape which demonstrate nursing in the VA to become a recruitment tool and to be utilized by any Nursing School receiving Federal money.

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Mundelein, Illinois 60060 (312) 949-6057

UNIVERSITY of PENNSYLVANIA

School of Nursing
Nursing Education Building
Philadelphia, PA 19104-6096
215-898-8281

8 June 1987

Senator Alan Cranston
Chairman
U.S. Senate, Committee on Veterans' Affairs
Washington, DC 20510-6375

Dear Senator Cranston,

I sincerely appreciate having the opportunity to present testimony related to the nursing shortage at the recent May 21, 1987 hearing of the U.S. Senate Committee on Veterans' Affairs. The following are my responses to the follow-up questions you posed:

1. What recruitment and retention tools--Saturday premium pay, tuition reimbursement, bonuses, or any other methods that you may know of--do you believe are the most effective?

I believe that tuition reimbursement for nursing education is a very effective strategy to promote the recruitment and retention of qualified nurses. Saturday premium pay and bonuses are short-term solutions which, in the private sectors at least, have not had any lasting impact. Recruitment bonuses, for example, have only served to promote job-hopping. When these bonuses have only applied to new recruits, they have had a negative impact on the morale of the experienced nurses.

In addition to the strategies outlined in number 2, the V.A. needs to engage in a public relations campaign that increases the visibility of nurses in their many roles throughout the system. The unique opportunities offered to nurses working the the system should be stressed.

2. In testimony it is stated that in order to encourage people to enter the nursing profession, the work environment and reward system for nursing must be enhanced. How could that best be accomplished?

The following are strategies proposed to enhance the work environment and reward system for nurses:

Goal: Creating meaningful growth opportunities for individuals choosing nursing as a career.

Strategy: Recruitment and retention of highly qualified nurses should be associated with the development of career ladders and an economic reward system that recognizes superior professional achievement. Salary compression is a major structural obstacle in hospitals' development of this system. The development of economic models that promote economic restructuring in the V.A. and eliminate or minimize salary compression should be supported by the federal government.

Strategy: Premier schools of nursing should collaborate with major V.A. hospitals in the development of centers for lifelong learning. Nurses cannot indefinitely continue in their fields without renewing their store of knowledge and clinical skills. The educational resources of select schools should be tapped to meet the needs of nurses in the V.A. over the span of their career.

Goal: Assuring optional federal support for nursing.

Strategy: A portion of federal dollars for nursing in the V.A. should be earmarked for demonstration projects which address the issue of recruitment and retention of highly qualified nurses in this system. An example of such projects that might be supported is the development of innovative nursing practice systems that will more effectively address the needs of select patient populations (i.e. AIDS patients, chronically mentally ill) and at the same time promote nurses as autonomous professionals.

Strategy: Increased federal support for scholarships, tuition reimbursement and other forms of financial aid for both undergraduate and graduate programs in nursing.

3. The V.A. employs approximately 32,000 registered nurses. If you had $50 million to spend any way you like for the purpose of improving the V.A.'s ability to recruit and retain nurses, how would you spend it--for more nurses, Saturday premium pay (about $20 million), tuition reimbursement (about $5-10 million), bonus pay (applied selectively) or in some other fashion?

I would spend the $50 million on the strategies such as those defined above which offer long-term solutions to the national nursing shortage. As noted in my response to question 1, I believe that bonuses and premium pay are short-term solutions that achieve no lasting changes in the work environment of nurses. They do not address the obstacles to professional growth that exists in many hospital settings--nursing's lack of autonomy in making decisions regarding patient care, the absence of collegial, collaborative relationships between nurses and physicians, and poorly defined opportunities for personal and professional growth, including economic advancement.

I hope these responses assist you in your deliberations regarding strategies to promote the recruitment and retention of qualified nurses in the V.A. system. Please do not hesitate to contact me if I can be of further assistance to you.

Sincerely,

Mary D. Naylor, Ph.D., F.A.A.N.
Associate Dean and Director of
Undergraduate Studies

gm

National Federation of Federal Employees

NFFE

James M. Peirce • President
Abraham Orlofsky • Secretary Treasurer

In reply refer to: ____________

June 3, 1987

Dear Chairman Cranston,

Thank you for the opportunity to testify before the Committee on the subject of the recruitment and retention problems among VA medical personnel. I hope the information provided was useful. I am now enclosing the additional material you requested regarding the National Federation of Federal Employee's bargaining units. I have listed only the professional employees since more specific details on the nonprofessional employees is not available. If you need additional information, please don't hesitate to contact me.

Sincerely,

Patricia Thomas
Legislative Director

1016 16th Street, NW; Washington, DC 20036; Phone: (202) 862-4400

NFFE National Vice Presidents:
Region 1, Georgiana Kachura, Huntington, NY
Region 2, Robert E. Estep, Jr., Chambersburg, PA
Region 3, A. B. Reynolds, Panama City, FL
Region 4, Richard E. Reiman, Terlton, OK
Region 5, William P. Davis, Parker, AZ
Region 6, Gene Needham, Port Hueneme, CA
Region 7, Charles Shelton, Sitka, AK
Region 8, Jan Lambert, Kansas City, MO
Region 9, Sheila Velazco, Muncie, IN

NATIONAL FEDERATION OF FEDERAL EMPLOYEES RESPONSE

Composition of the NFFE bargaining units within the Veterans' Administration hospital system.

Professionals

Total employees represented...................... 3,139

Classifications

Audiologist	8
Research Biologist	1
Chaplain	34
Chemist	1
Research Chemist	8
Dentist	32
Dietician	41
Biomedical Engineer	3
Biochemical Engineer	1
General Engineer	12
Industrial Engineer	2
Medical Technician	221
Nuclear Medical Tech	5
Nurse	1,870
Nurse Anesthetist	16
Optometrist	1
Pharmacist	120
Pharmacologist	1
Physician	506
Physician Assistant	25
Podiatrist	5
Psychologist	7
Clinical Psychologist	23
Counseling Psychologist	34
Social Worker	108
Speech Pathologist	5
Corrective Therapist	18
Manual Art Therapist	3
Physical Therapist	8
Occupational Therapist	10
Recreational Therapist	10

WRITTEN QUESTIONS FROM CHAIRMAN CRANSTON TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: **A. What information must a VAMC document to justify the needs for special rates?**

Answer: Each facility requesting special rates for an occupation provides information which describes the nature and extent of recruitment or retention problems, the effect of these problems on the provision of patient care, the comparability of non-VA salary rates in the local labor market, and the impact of proposed rates on the facility's budget. Specifically, DM&S Supplement, MP-5, Part II, Chapter 3, Sections C and D delineate the information to be submitted. Supporting data requested include:

- o Occupation(s) by series, grade, title and any specialization for which rates are being proposed.
- o Geographic area and VA locations for which rates are recommended.
- o Number of filled and vacant positions at the time of the request as well as for one year prior to the submission.
- o Number of any additional positions which may be authorized over the next 12 months.
- o Information on the average length of time the positions have been vacant.
- o Number of quits for each of the preceding four quarters and reasons for quits.
- o Information on the number of declinations received in proportion to job offers, and reasons for declinations.
- o Description of recruiting efforts including area covered, methods used, contacts made, etc.
- o Extent of use of internal placement and training programs.
- o Working conditions or other factors contributing to recruitmentor retention difficulties.
- o Information on higher non-Federal pay rates, including data on pay practices, hours worked, vacancy information, other significant labor market indicators for comparable occupational groups in the non-Federal sector of the labor market.
- o Budget estimates.

Question: B. Are there specific guidelines as to what the vacancy or turnover rate should be prior to facilities requesting special rates?

Answer: The characteristics of the occupations and the particular staffing situations at each facility may vary significantly; therefore, it has been determined that it is generally not practical or advisable to establish specific vacancy or turnover rates as guidelines. Rather, it is best if the Department permits the local management to determine the extent of their difficulties and to request special rates accordingly.

Question: C. How long does the approval process for special rates take from the time a request leaves the field facility to the time a response is received from VACO? Please provide a separate response for those employees covered by Title 38, Hybrid Personnel, and those employees covered by Title 5.

Answer: Generally, the approval process for Title 38 and "Hybrid" categories of employees takes an average of 6 to 7 weeks. This includes time for staffing the request, including obtaining additional information from the facility if needed, coordinating with regional and local management, obtaining Departmental concurrences, the Chief Medical Director's approval, and notifying the facility.

The approval process for Title 5 health-care personnel takes an average of 7 to 8 weeks in VA, and an additional 6 week average for OPM review, for a total of 13 - 14 weeks.

Question: D. I know in the past, that VAMC's which were granted authority to pay special salary rates had to do so out of previously budgeted funds. That obviously is a significant disincentive to requesting or implementing such rates. What steps can be taken to fund such rates from other sources?

Answer: Request for special salary rates contingent upon the availability of local VA facility funding were significantly inhibited because of local financial demands. Numerous efforts have been made to fund all requests in their entirety. Regional and Central Office funds have been redistributed from existing availability from NRM, Equipment and other nonrecurring sources.

Question: E. If additional funds are needed to support the increased pay rates, will this process take a longer time and, if so, how much longer?

Answer: The funding source does not increase the length of time involved in getting such approvals. Funds set aside for other purposes are used.

QUESTION: Would section 2 of S. 6, "Services to Overcome Service-Connected Disabilities Affecting Procreation", provide new authority to the Veterans Administration to offer an electro-ejaculation procedure combined with artificial insemination (as described in the attached article) in order to overcome a service-connected disability impairing the veteran's procreative ability, or does the VA already possess that authority?

ANSWER: VA does not now have legal authority to conduct, or pay for the conduct of an electro-ejaculation procedure. Section 2 of S. 6 would provide new authority to furnish such services in connection with artificial insemination or in vitro fertilization.

The purpose of the electro-ejaculation procedure described in the article you enclosed with your letter is to obtain sperm to facilitate the artificial insemination of a woman. Because VA generally has legal authority to furnish hospital care and medical services only to eligible veterans, artificial insemination could not be provided under existing law to the non-veteran wife of a male veteran. If there is no authority to provide artificial insemination, there is no authority to obtain the sperm to perform the insemination.

WRITTEN QUESTIONS FROM SENATOR MURKOWSKI TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. Your testimony states that the VA opposed recruitment and retention bills proposed by Senator Cranston and myself. The VA would rather defer action on these bills until the Task Force identifies long-term solutions to these issues.

Dr. Gronvall, when will the Task Force complete its study?

Answer: Although activities of the Task Force may continue for an extended period of time, an initial report with recommendations is expected in early July, 1987.

Question: 2. I view the serious recruitment and retention problems which the VA faces as critical and, in fact, ones that require immediate attention. Is it wise to delay legislative action until such a time as the Task Force work can be completed?

Answer: I share the concern that many of the problems are critical and require prompt action and for that reason have requested that the Task Force expedite its activities so that I may have the initial report in early July 1987. The Task Force's analyses and recommendations will provide me with information I need in order to recommend the appropriate course of action to the Administrator and, in turn, to the Congress. In the interim, as indicated in my testimony, the Department has taken a number of administrative actions in an effort to address the recruitment and retention issues. These have included an identification of $2.5 million for tuition assistance and expedited action on special rate requests as well as additional funding for special rates.

Question: 3. I understand that relative to the VA's existing authority to provide special pay rates to achieve adequate staffing that the VA pays special rates to all nurses at a VA medical facility -- when, in fact, the recruitment and retention problem may not be a facility-wide problem.

In that regard, is the VA providing this benefit in locations or clinical specialties where it may not be neccessary in order to ensure salary equality at the facility?

Answer: The VA policy provides for the authorization of special salary rates for categories of employees within a specialization of an occupation, e.g., operating room nurses. Currently, specialized authorizations exist as follow:

Operating Room Nurses (Full Grade) - VAMC Madison, WI
Operating Room Nurses - 35% On-Call rate - VAMC, West LA
Critical Care Nurses - 15% Saturday Premium Pay - VAMC, Washington, D.C.

The majority of our nurse special rate authorizations cover all nurses at a facility who are in the specified grades of the authorization. Generally, the grades covered are the entry levels of Junior and Associate grade, but, when necessary, special rates are also authorized at Full, Intermediate, and Senior grades.

Question: 4. Dr. Gronvall, on page 17 of your testimony you state "As the Chief Medical Director, I can approve special pay rates for registered nurses, physical therapists, and other title 38 employees." It is my understanding that the approval process is, in fact, time consuming and burdensome. The Office of Personnel is deeply involved in the decision making process and actually sets the special pay rates and not your office. In some cases this can take 6 to 9 months. Am I correct?

Answer: As the Chief Medical Director, I have final approval authority for special rates for Registered Nurses, Nurse Anesthetists, Licensed Practical Nurses, Physical Therapists, and Respiratory Therapists. My decision is based on the technical and informed input of the VA's Office of Personnel and Labor Relations, as well as the Regional Directors, and the DM&S Special Rates Consortium that reviews all recommended authorizations. At the present time, special rate approvals for these occupations typically average 6 weeks from the date of receipt in VACO. As statutorily required, special rate authorizations for other health care occupations are reviewed after approval in the VA by the Office of Personnel Management (OPM) which typically occurs in about 45 days. Thus, the total time for these OPM reviewed cases is about 90 days.

PROCUREMENT

Question: Why are new drugs available through local purchase and not available through the VA's depot system?

Answer: It is necessary for us to analyze demand histories for new drugs prior to making central depot stocking decisions. Absence of such analysis could result in cost ineffective acquisition decisions.

It should be emphasized that the fact that a drug is not depot stocked does not necessarily mean it is not centrally managed through such programs as Federal Supply Schedules. In fact, in FY 1986 only 15 percent of the dollars expended for drugs and medicines were local contracts. Often FSS is an appropriate intermediary step between local contracting and depot stocking. We are able to negotiate requirements contracts using Federal buying power and then assess the viability and profitability of making definitive acquisition commitments through depot distribution.

Question: Do you believe that the VA currently takes advantage of its purchasing power to obtain the most favorable prices?

Answer: We believe the VA has been in the vanguard of agencies in using its concerted buying power to its economic gain.

As early as 1977 in the GAO report "Uninformed Procurement Decisions for Commercial Products Are Costly" it was concluded that the VA central distribution stocking decision process, with certain needed refinements, ensures cost-effective centralized procurements.

While acknowledging that many commodities and services do not currently lend themselves to national acquisitions, we have for the past several years utilized consolidated medical district acquisition to gain economic advantage through aggregating requirements on a geographic basis. In FY 1986, we identified $1.25 million in savings through district consolidated procurements and expect that savings to be considerably exceeded this fiscal year.

We are aware of the need to improve our acquisition system in order to increase our economic advantage. The Coopers and Lybrand report identified several areas which were fertile for such improvements and we believe we are taking full advantage of such opportunities.

Question: Specifically, what changes have been implemented system-wide in VA procurement policy since the release of the Coopers and Lybrand study almost a year ago? Am I correct in assuming that your testimony indicates that almost a year after the study was completed you are still analyzing and identifying items for possible standardization and that no savings have been achieved? If savings have been achieved, please indicate the total amount and source.

Answer: As a result of the Coopers and Lybrand Study we have taken numerous actions to further the objective of making full use of our buying power and to make better use of available acquisition strategies. Such important initiatives include the following:

1. Establishing a price monitoring strategy to be staffed at VA Marketing Center.

2. Development of a standard operational procedure for determining the viability and benefits of multiyear and option year contracts for depot stocking and other centralized acquisition programs.

3. In FY 1987, 192 new items have been added to the depot with an aggregated projected cost avoidance of $22 million.

4. Expansion of the use of the Marketing Center contracting techniques termed by Coopers and Lybrand as "National Contract Program." The technique, which is a requirements contract concept, has been expanded to include insulin with an expected savings of $1.5 million. Additionally, we are considering expanding the IV solution contract to include 100 line items and to convert the contract to single award.

5. Thirty-two items have been identified for the initial pilot test of standardization under the new standardization procedure. Additionally, definitive guidelines and reporting procedures have been developed in order to make standardization a permanent process in the VA. The directive has been circulated for formal VA concurrence.

Question: Do you believe that there should be a limitation on local purchase?

a. If no, why not?

b. If so, what should the limitation be?

ANSWER: We have endorsed the concept of limitation of open market procurement and have developed performance standards to be met by our heads of contracting activity in this regard. However, developing a standard that is equitable has proven difficult and there have been several modifications to the performance standard, e.g., in order to acknowledge the criticism that an individual activity may not have equal opportunity to utilize national contracts, we have included district-wide consolidations as an acquisition that is not to be considered local.

It is important to note that, through our various related efforts to maximize national contracts, we have reduced local procurements for supplies and equipment from 41.7 percent in FY 1981 to a FY 1986 level of 29.6 percent.